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CUMULATIVE TABLE OF VIRGINIA ADMINISTRATIVE CODE SECTIONS ADOPTED, AMENDED, OR REPEALED

The table printed below lists regulation sections, by Virginia Administrative Code (VAC) title, that have been amended, added or repealed in the *Virginia Register* since the regulations were originally published or last supplemented in VAC (the Spring 2002 VAC Supplement includes final regulations published through *Virginia Register* Volume 18, Issue 11, dated February 11, 2002). Emergency regulations, if any, are listed, followed by the designation "emer," and errata pertaining to final regulations are listed. Proposed regulations are not listed here. The table lists the sections in numerical order and shows action taken, the volume, issue and page number where the section appeared, and the effective date of the section.

| SECTION NUMBER | ACTION | CITE | EFFECTIVE DATE |
|--|----------|-----------------------|----------------|
| Title 4. Conservation and Natural Resources | | | |
| 4 VAC 5-35-10 through 4 VAC 5-35-50 | Repealed | 18:14 VA.R. 1800 | 4/25/02 |
| 4 VAC 5-36-10 through 4 VAC 5-36-210 | Added | 18:14 VA.R. 1800-1827 | 4/25/02 |
| 4 VAC 20-270-30 | Amended | 18:14 VA.R. 1827 | 3/5/02 |
| 4 VAC 20-270-40 | Amended | 18:14 VA.R. 1828 | 3/5/02 |
| 4 VAC 20-270-55 | Amended | 18:14 VA.R. 1828 | 3/5/02 |
| 4 VAC 20-270-56 | Added | 18:14 VA.R. 1828 | 3/5/02 |
| 4 VAC 20-560-20 | Erratum | 18:14 VA.R. 1911 | -- |
| 4 VAC 20-560-20 emer | Amended | 18:14 VA.R. 1904 | 3/4/02-3/31/02 |
| 4 VAC 20-560-20 | Amended | 18:16 VA.R. 2054 | 4/1/02 |
| 4 VAC 20-560-50 emer | Amended | 18:14 VA.R. 1905 | 3/4/02-3/31/02 |
| 4 VAC 20-560-50 | Amended | 18:16 VA.R. 2055 | 4/1/02 |
| 4 VAC 20-620-20 | Amended | 18:14 VA.R. 1828 | 3/5/02 |
| 4 VAC 20-620-40 | Amended | 18:12 VA.R. 1646 | 1/31/02 |
| 4 VAC 20-620-50 | Amended | 18:14 VA.R. 1828 | 3/5/02 |
| 4 VAC 20-620-60 | Amended | 18:14 VA.R. 1829 | 3/5/02 |
| 4 VAC 20-620-70 | Amended | 18:14 VA.R. 1829 | 3/5/02 |
| 4 VAC 20-720-47 emer | Added | 18:12 VA.R. 1697 | 2/1/02-2/28/02 |
| 4 VAC 20-950-30 | Amended | 18:14 VA.R. 1829 | 3/4/02 |
| 4 VAC 20-950-40 | Amended | 18:14 VA.R. 1829 | 3/4/02 |
| 4 VAC 20-950-45 | Amended | 18:12 VA.R. 1647 | 1/31/02 |
| 4 VAC 20-950-45 | Amended | 18:14 VA.R. 1830 | 3/4/02 |
| 4 VAC 20-950-45 | Amended | 18:16 VA.R. 2055 | 4/1/02 |
| 4 VAC 50-20-30 | Amended | 18:14 VA.R. 1831 | 7/1/02 |
| 4 VAC 50-20-50 | Amended | 18:14 VA.R. 1832 | 7/1/02 |
| 4 VAC 50-20-50 | Erratum | 18:17 VA.R. 2183 | -- |
| 4 VAC 50-20-70 | Amended | 18:14 VA.R. 1832 | 7/1/02 |
| 4 VAC 50-20-120 | Amended | 18:14 VA.R. 1834 | 7/1/02 |
| 4 VAC 50-20-220 | Amended | 18:14 VA.R. 1834 | 7/1/02 |
| 4 VAC 50-20-320 | Amended | 18:14 VA.R. 1835 | 7/1/02 |
| Title 6. Criminal Justice and Corrections | | | |
| 6 VAC 20-171-10 | Amended | 18:15 VA.R. 1955 | 5/10/02 |
| 6 VAC 20-171-50 | Amended | 18:15 VA.R. 1957 | 5/10/02 |
| 6 VAC 20-171-120 | Amended | 18:15 VA.R. 1958 | 5/10/02 |
| 6 VAC 20-171-200 | Amended | 18:15 VA.R. 1958 | 5/10/02 |
| 6 VAC 20-171-220 | Amended | 18:15 VA.R. 1959 | 5/10/02 |
| 6 VAC 20-171-230 | Amended | 18:15 VA.R. 1960 | 5/10/02 |
| 6 VAC 20-171-240 | Amended | 18:15 VA.R. 1961 | 5/10/02 |
| 6 VAC 20-171-250 | Amended | 18:15 VA.R. 1961 | 5/10/02 |
| 6 VAC 20-171-260 | Amended | 18:15 VA.R. 1962 | 5/10/02 |
| 6 VAC 20-171-280 | Amended | 18:15 VA.R. 1963 | 5/10/02 |
| 6 VAC 20-171-310 | Amended | 18:15 VA.R. 1964 | 5/10/02 |
| 6 VAC 20-171-320 | Amended | 18:15 VA.R. 1964 | 5/10/02 |
| 6 VAC 20-171-330 | Amended | 18:15 VA.R. 1965 | 5/10/02 |
| 6 VAC 20-171-340 | Amended | 18:15 VA.R. 1965 | 5/10/02 |

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| SECTION NUMBER | ACTION | CITE | EFFECTIVE DATE |
|---|----------|-----------------------|----------------|
| 6 VAC 20-171-350 | Amended | 18:15 VA.R. 1966 | 5/10/02 |
| 6 VAC 20-171-445 | Amended | 18:15 VA.R. 1968 | 5/10/02 |
| 6 VAC 20-171-450 | Amended | 18:15 VA.R. 1968 | 5/10/02 |
| 6 VAC 20-171-480 | Amended | 18:15 VA.R. 1968 | 5/10/02 |
| 6 VAC 20-171-520 | Amended | 18:15 VA.R. 1969 | 5/10/02 |
| 6 VAC 20-171-530 | Amended | 18:15 VA.R. 1969 | 5/10/02 |
| 6 VAC 20-171-540 | Amended | 18:15 VA.R. 1969 | 5/10/02 |
| Title 8. Education | | | |
| 8 VAC 20-21-10 | Amended | 18:12 VA.R. 1648 | 3/28/02 |
| 8 VAC 20-21-40 | Amended | 18:12 VA.R. 1649 | 3/28/02 |
| 8 VAC 20-21-50 | Amended | 18:12 VA.R. 1650 | 3/28/02 |
| 8 VAC 20-21-90 | Amended | 18:12 VA.R. 1651 | 3/28/02 |
| 8 VAC 20-21-100 | Amended | 18:12 VA.R. 1651 | 3/28/02 |
| 8 VAC 20-21-120 | Amended | 18:12 VA.R. 1652 | 3/28/02 |
| 8 VAC 20-21-170 | Amended | 18:12 VA.R. 1653 | 3/28/02 |
| 8 VAC 20-21-590 | Amended | 18:12 VA.R. 1653 | 3/28/02 |
| 8 VAC 20-21-660 | Amended | 18:12 VA.R. 1655 | 3/28/02 |
| 8 VAC 20-21-680 | Amended | 18:12 VA.R. 1656 | 3/28/02 |
| 8 VAC 20-80-30 | Amended | 18:12 VA.R. 1657 | 3/27/02 |
| 8 VAC 20-80-40 | Amended | 18:12 VA.R. 1660 | 3/27/02 |
| 8 VAC 20-80-54 | Amended | 18:12 VA.R. 1661 | 3/27/02 |
| 8 VAC 20-80-56 | Amended | 18:12 VA.R. 1664 | 3/27/02 |
| 8 VAC 20-80-60 | Amended | 18:12 VA.R. 1666 | 3/27/02 |
| 8 VAC 20-80-66 | Amended | 18:12 VA.R. 1668 | 3/27/02 |
| 8 VAC 20-80-70 | Amended | 18:12 VA.R. 1671 | 3/27/02 |
| 8 VAC 20-80-76 | Amended | 18:12 VA.R. 1676 | 3/27/02 |
| 8 VAC 20-630-10 through 8 VAC 20-630-70 | Added | 18:12 VA.R. 1683-1684 | 3/28/02 |
| Title 9. Environment | | | |
| 9 VAC 5-40-160 through 9 VAC 5-40-230 | Repealed | 18:14 VA.R. 1836-1840 | 5/1/02 |
| 9 VAC 5-50-160 through 9 VAC 5-50-230 | Repealed | 18:14 VA.R. 1840-1844 | 5/1/02 |
| 9 VAC 5-60-200 through 9 VAC 5-60-270 | Added | 18:14 VA.R. 1836-1840 | 5/1/02 |
| 9 VAC 5-60-200 | Erratum | 18:17 VA.R. 2183 | -- |
| 9 VAC 5-60-300 through 9 VAC 5-60-370 | Added | 18:14 VA.R. 1840-1844 | 5/1/02 |
| 9 VAC 5-60-300 | Erratum | 18:17 VA.R. 2183 | -- |
| 9 VAC 5-80-2000 through 9 VAC 5-80-2090 | Amended | 18:14 VA.R. 1845-1852 | 5/1/02 |
| 9 VAC 5-80-2100 | Repealed | 18:14 VA.R. 1852 | 5/1/02 |
| 9 VAC 5-80-2110 | Amended | 18:14 VA.R. 1852 | 5/1/02 |
| 9 VAC 5-80-2120 | Amended | 18:14 VA.R. 1852 | 5/1/02 |
| 9 VAC 5-80-2150 | Amended | 18:14 VA.R. 1853 | 5/1/02 |
| 9 VAC 5-80-2160 | Repealed | 18:14 VA.R. 1853 | 5/1/02 |
| 9 VAC 5-80-2180 | Amended | 18:14 VA.R. 1853 | 5/1/02 |
| 9 VAC 5-80-2190 | Amended | 18:14 VA.R. 1853 | 5/1/02 |
| 9 VAC 5-80-2200 | Added | 18:14 VA.R. 1853 | 5/1/02 |
| 9 VAC 5-80-2210 | Added | 18:14 VA.R. 1853 | 5/1/02 |
| 9 VAC 5-80-2220 | Added | 18:14 VA.R. 1853 | 5/1/02 |
| 9 VAC 5-80-2230 | Added | 18:14 VA.R. 1853 | 5/1/02 |
| 9 VAC 5-80-2240 | Added | 18:14 VA.R. 1853 | 5/1/02 |
| 9 VAC 10-20-40 | Erratum | 18:13 VA.R. 1763 | -- |
| 9 VAC 10-20-130 | Erratum | 18:13 VA.R. 1764 | -- |
| 9 VAC 10-20-181 | Erratum | 18:13 VA.R. 1764 | -- |
| 9 VAC 10-20-191 | Erratum | 18:13 VA.R. 1764 | -- |
| 9 VAC 20-60 | Erratum | 18:12 VA.R. 1714 | -- |
| 9 VAC 25-260-50 | Amended | 17:16 VA.R. 2381 | 6/5/02* |

* Notice of effective date published in 18:17 VA.R. 2174

Cumulative Table of VAC Sections Adopted, Amended, or Repealed

| SECTION NUMBER | ACTION | CITE | EFFECTIVE DATE |
|--|----------|-----------------------|----------------|
| 9 VAC 25-260-55 | Added | 17:16 VA.R. 2381 | 6/5/02* |
| Title 12. Health | | | |
| 12 VAC 5-65 | Repealed | 18:12 VA.R. 1685 | 3/27/02 |
| 12 VAC 5-66-10 through 12 VAC 5-66-80 | Added | 18:12 VA.R. 1685-1688 | 3/27/02 |
| 12 VAC 5-66-10 through 12 VAC 5-66-80 | Erratum | 18:13 VA.R. 1764 | -- |
| 12 VAC 5-120-10 through 12 VAC 5-120-90 | Added | 18:16 VA.R. 2057-2058 | 5/22/02 |
| 12 VAC 5-475-10 through 12 VAC 5-475-90 | Added | 18:12 VA.R. 1691 | 3/27/02 |
| 12 VAC 5-520-10 | Amended | 18:15 VA.R. 1969 | 5/8/02 |
| 12 VAC 5-520-20 | Amended | 18:15 VA.R. 1969 | 5/8/02 |
| 12 VAC 5-520-30 | Amended | 18:15 VA.R. 1969 | 5/8/02 |
| 12 VAC 5-520-40 through 12 VAC 5-520-70 | Repealed | 18:15 VA.R. 1969 | 5/8/02 |
| 12 VAC 5-520-80 | Amended | 18:15 VA.R. 1969 | 5/8/02 |
| 12 VAC 5-520-90 through 12 VAC 5-520-120 | Repealed | 18:15 VA.R. 1969 | 5/8/02 |
| 12 VAC 5-520-130 through 12 VAC 5-520-210 | Added | 18:15 VA.R. 1969 | 5/8/02 |
| 12 VAC 30-120-10 emer | Amended | 18:12 VA.R. 1698 | 2/1/02-1/31/03 |
| 12 VAC 30-120-40 emer | Amended | 18:12 VA.R. 1699 | 2/1/02-1/31/03 |
| 12 VAC 30-120-50 emer | Amended | 18:12 VA.R. 1701 | 2/1/02-1/31/03 |
| 12 VAC 30-120-55 emer | Added | 18:12 VA.R. 1702 | 2/1/02-1/31/03 |
| 12 VAC 30-120-60 emer | Amended | 18:12 VA.R. 1704 | 2/1/02-1/31/03 |
| 12 VAC 30-150-10 through 12 VAC 30-150-100 | Added | 18:17 VA.R. 2174 | 6/6/02 |
| 12 VAC 35-20 | Repealed | 18:12 VA.R. 1691 | 3/27/02 |
| 12 VAC 35-140 | Repealed | 18:12 VA.R. 1691 | 3/27/02 |
| 12 VAC 35-150 | Repealed | 18:12 VA.R. 1691 | 3/27/02 |
| 12 VAC 35-160 | Repealed | 18:12 VA.R. 1691 | 3/27/02 |
| 12 VAC 35-200-10 | Amended | 18:16 VA.R. 2059 | 5/22/02 |
| 12 VAC 35-200-20 | Amended | 18:16 VA.R. 2060 | 5/22/02 |
| 12 VAC 35-200-30 | Amended | 18:16 VA.R. 2061 | 5/22/02 |
| Title 14. Insurance | | | |
| 14 VAC 5-80-160 through 14 VAC 5-80-190 | Repealed | 18:14 VA.R. 1896 | 3/31/02 |
| 14 VAC 5-390-20 | Amended | 18:12 VA.R. 1692 | 2/1/02 |
| 14 VAC 5-390-30 | Amended | 18:12 VA.R. 1692 | 2/1/02 |
| 14 VAC 5-390-40 | Amended | 18:12 VA.R. 1692 | 2/1/02 |
| Title 18. Professional and Occupational Licensing | | | |
| 18 VAC 90-30-20 | Amended | 18:15 VA.R. 1970 | 5/8/02 |
| 18 VAC 90-30-100 | Amended | 18:15 VA.R. 1970 | 5/8/02 |
| 18 VAC 90-30-105 | Added | 18:15 VA.R. 1970 | 5/8/02 |
| 18 VAC 90-30-220 | Amended | 18:15 VA.R. 1970 | 5/8/02 |
| 18 VAC 90-40-20 | Amended | 18:15 VA.R. 1977 | 5/8/02 |
| 18 VAC 90-40-50 | Amended | 18:15 VA.R. 1977 | 5/8/02 |
| 18 VAC 90-40-55 | Added | 18:15 VA.R. 1977 | 5/8/02 |
| 18 VAC 90-40-60 | Amended | 18:15 VA.R. 1977 | 5/8/02 |
| 18 VAC 90-40-130 | Amended | 18:15 VA.R. 1977 | 5/8/02 |
| 18 VAC 110-20-20 | Amended | 18:12 VA.R. 1693 | 3/27/02 |
| 18 VAC 110-20-270 | Amended | 18:12 VA.R. 1693 | 3/27/02 |
| 18 VAC 110-20-280 | Amended | 18:12 VA.R. 1693 | 3/27/02 |
| 18 VAC 110-20-285 | Amended | 18:12 VA.R. 1694 | 3/27/02 |
| 18 VAC 110-20-430 | Amended | 18:12 VA.R. 1694 | 3/27/02 |
| 18 VAC 125-10-10 | Amended | 18:12 VA.R. 1694 | 3/27/02 |
| 18 VAC 125-10-20 | Amended | 18:12 VA.R. 1694 | 3/27/02 |
| 18 VAC 125-10-30 | Amended | 18:12 VA.R. 1695 | 3/27/02 |
| 18 VAC 125-10-40 | Amended | 18:12 VA.R. 1695 | 3/27/02 |
| 18 VAC 125-10-60 | Amended | 18:12 VA.R. 1695 | 3/27/02 |
| 18 VAC 125-10-70 | Amended | 18:12 VA.R. 1695 | 3/27/02 |
| 18 VAC 125-10-80 | Amended | 18:12 VA.R. 1695 | 3/27/02 |
| 18 VAC 125-10-100 | Amended | 18:12 VA.R. 1695 | 3/27/02 |
| 18 VAC 125-30 (Forms) | Amended | 18:15 VA.R. 1985 | -- |

Cumulative Table of VAC Sections Adopted, Amended, or Repealed

| SECTION NUMBER | ACTION | CITE | EFFECTIVE DATE |
|--|----------|-----------------------|----------------|
| 18 VAC 125-30-10 through 18 VAC 125-30-50 | Amended | 18:13 VA.R. 1753-1754 | 4/10/02 |
| 18 VAC 125-30-60 | Repealed | 18:13 VA.R. 1754 | 4/10/02 |
| 18 VAC 125-30-80 | Amended | 18:13 VA.R. 1755 | 4/10/02 |
| 18 VAC 125-30-90 | Amended | 18:13 VA.R. 1755 | 4/10/02 |
| Title 20. Public Utilities and Telecommunications | | | |
| 20 VAC 5-423-10 through 20 VAC 5-423-90 | Added | 18:14 VA.R. 1899-1902 | 3/6/02 |
| Title 22. Social Services | | | |
| 22 VAC 15-10-10 | Amended | 18:14 VA.R. 1902 | 5/1/02 |
| 22 VAC 15-10-30 | Amended | 18:14 VA.R. 1902 | 5/1/02 |
| 22 VAC 15-10-40 | Amended | 18:14 VA.R. 1902 | 5/1/02 |
| 22 VAC 15-10-50 | Amended | 18:14 VA.R. 1902 | 5/1/02 |
| 22 VAC 15-10-60 | Amended | 18:14 VA.R. 1902 | 5/1/02 |
| 22 VAC 15-10-70 | Amended | 18:14 VA.R. 1902 | 5/1/02 |
| 22 VAC 40-41-10 | Amended | 18:12 VA.R. 1696 | 4/1/02 |
| 22 VAC 40-41-20 | Amended | 18:12 VA.R. 1696 | 4/1/02 |
| 22 VAC 40-41-40 | Amended | 18:12 VA.R. 1696 | 4/1/02 |
| 22 VAC 40-41-50 | Amended | 18:12 VA.R. 1696 | 4/1/02 |
| 22 VAC 40-41-55 | Added | 18:12 VA.R. 1696 | 4/1/02 |
| 22 VAC 40-880-10 | Amended | 18:14 VA.R. 1903 | 4/24/02 |
| 22 VAC 40-880-30 | Amended | 18:14 VA.R. 1903 | 4/24/02 |
| 22 VAC 40-880-60 | Amended | 18:14 VA.R. 1903 | 4/24/02 |
| 22 VAC 40-880-80 | Amended | 18:14 VA.R. 1903 | 4/24/02 |
| 22 VAC 40-880-110 | Amended | 18:14 VA.R. 1903 | 4/24/02 |
| 22 VAC 40-880-120 | Amended | 18:14 VA.R. 1903 | 4/24/02 |
| 22 VAC 40-880-130 | Amended | 18:14 VA.R. 1903 | 4/24/02 |
| 22 VAC 40-880-170 | Amended | 18:14 VA.R. 1903 | 4/24/02 |
| 22 VAC 40-880-190 | Amended | 18:14 VA.R. 1903 | 4/24/02 |
| 22 VAC 40-880-200 through 22 VAC 40-880-300 | Amended | 18:14 VA.R. 1903 | 4/24/02 |
| 22 VAC 40-880-270 | Erratum | 18:17 VA.R. 2183 | -- |
| 22 VAC 40-880-290 | Erratum | 18:17 VA.R. 2183 | -- |
| 22 VAC 40-880-320 | Amended | 18:14 VA.R. 1903 | 4/24/02 |
| 22 VAC 40-880-330 | Amended | 18:14 VA.R. 1903 | 4/24/02 |
| 22 VAC 40-880-340 | Amended | 18:14 VA.R. 1903 | 4/24/02 |
| 22 VAC 40-880-360 | Amended | 18:14 VA.R. 1903 | 4/24/02 |
| 22 VAC 40-880-380 | Amended | 18:14 VA.R. 1903 | 4/24/02 |
| 22 VAC 40-880-385 | Added | 18:14 VA.R. 1903 | 4/24/02 |
| 22 VAC 40-880-410 | Amended | 18:14 VA.R. 1903 | 4/24/02 |
| 22 VAC 40-880-430 | Amended | 18:14 VA.R. 1903 | 4/24/02 |
| 22 VAC 40-880-440 | Amended | 18:14 VA.R. 1903 | 4/24/02 |
| 22 VAC 40-880-480 through 22 VAC 40-880-520 | Amended | 18:14 VA.R. 1903 | 4/24/02 |
| 22 VAC 40-880-550 | Amended | 18:14 VA.R. 1903 | 4/24/02 |
| 22 VAC 40-880-560 | Amended | 18:14 VA.R. 1903 | 4/24/02 |
| 22 VAC 40-880-650 | Amended | 18:14 VA.R. 1903 | 4/24/02 |
| 22 VAC 40-880-670 | Amended | 18:14 VA.R. 1903 | 4/24/02 |
| 22 VAC 40-880-680 | Amended | 18:14 VA.R. 1903 | 4/24/02 |
| 22 VAC 40-880-700 | Amended | 18:14 VA.R. 1903 | 4/24/02 |
| 22 VAC 40-880-720 | Added | 18:14 VA.R. 1903 | 4/24/02 |

NOTICES OF INTENDED REGULATORY ACTION

Symbol Key

† Indicates entries since last publication of the *Virginia Register*

TITLE 12. HEALTH

STATE BOARD OF HEALTH

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the State Board of Health intends to consider repealing regulations entitled: **12 VAC 5-480. Radiation Protection Regulations**, and promulgating regulations entitled: **12 VAC 5-481. Radiation Protection Regulations**. The purpose of the proposed action is to repeal the current regulation concurrently with the promulgation of a new regulation (12 VAC 5-481). The current regulation was revised in 1987 and is seriously outdated and inconsistent with federal regulations and other national standards. The regulations will include adoption of the Suggested State Regulations for Control of Radiation published by the Conference of Radiation Control Program Directors, Inc., and adoption of the changes made in 1992 to the federal radiation protection standards, Part 10 CFR 20. In addition, the agency will implement legislation enacted in the 1999 and 2000 sessions of the General Assembly regarding civil penalties for violations of radioactive materials licenses and inspections of mammography machines.

The agency does not intend to hold a public hearing on the proposed regulations after publication in the *Virginia Register*.

Statutory Authority: §§ 32.1-12 and 32.1-229 of the Code of Virginia.

Public comments may be submitted until May 24, 2002.

Contact: Leslie P. Foldesi, Director, Radiological Health, Department of Health, 1500 E. Main St., Room 240, Richmond, VA 23219, telephone (804) 371-4029, FAX (804) 786-6979, toll-free 1-800-468-0138, e-mail LFOLDESI@vdh.state.va.us.

VA.R. Doc. No. R02-157; Filed April 4, 2002, 11:26 a.m.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Department of Medical Assistance Services intends to consider amending regulations entitled: **12 VAC 30-50. Amount, Duration, and Scope of Medical and Remedial Care Services**. The purpose of the proposed action is to amend the DMAS community mental health services regulations. The potential amendments cover a range of topics: billing units, provider license qualifications,

emergency response capability, provider acceptance of all individuals without regard to their ability to pay for services, providers permitted to perform evaluations and several federally mandated changes. The purpose of these revisions is to facilitate the delivery of services to Medicaid recipients.

The agency does not intend to hold a public hearing on the proposed regulation after publication.

Statutory Authority: § 32.1-325 of the Code of Virginia.

Public comments may be submitted until June 20, 2002.

Contact: Catherine Hancock, MH Policy Analyst, Policy Division, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219, telephone (804) 225-4272, FAX (804) 786-1680 or e-mail chancock@dmass.state.va.us.

VA.R. Doc. No. R02-164; Filed April 29, 2002, 2:41 p.m.

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Department of Medical Assistant Services intends to consider amending regulations entitled: **12 VAC 30-90. Methods and Standards for Establishing Payment Rates-Long Term Care Services: Nursing Home Payment System**. The purpose of the proposed action is to add a new requirement to the Nursing Home Payment System that each nursing facility submit a quarterly report of Medicaid credit balances. A credit balance would be defined as an improper or excess payment made to a provider as a result of patient billing or claims processing errors. Therefore, for each credit balance, the nursing facility would be required to submit to DMAS either the payment of the credit balance or an adjustment claim to correct any billing or claims processing errors.

The agency does not intend to hold a public hearing on the proposed regulation after publication.

Statutory Authority: § 32.1-325 of the Code of Virginia.

Public comments may be submitted until June 20, 2002.

Contact: James Branham, Reimbursement Analyst, Division of Cost Settlement and Reimbursement Division, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219, telephone (804) 225-4587, FAX (804) 786-0729 or e-mail jbranham@dmass.state.va.us.

VA.R. Doc. No. R02-166; Filed April 29, 2002, 2:41 p.m.

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Department of Medical Assistant Services intends to consider amending regulations entitled: **12 VAC 30-110. Eligibility and Appeals**. The purpose of this

Notices of Intended Regulatory Action

regulatory action is to promulgate state regulations concerning which individuals are authorized to sign Medicaid applications. In the past, the department has found itself faced with applications filed without the knowledge and approval of the applicant or filed on behalf of incompetent or incapacitated individuals by others who have no legal authority to conduct business on behalf of the applicant. To ensure that applications are only filed with the full knowledge and consent of an applicant or by someone legally acting on his behalf, the department proposes this regulation.

The agency does not intend to hold a public hearing on the proposed regulation after publication.

Statutory Authority: § 32.1-325 of the Code of Virginia.

Public comments may be submitted until June 20, 2002.

Contact: Patricia A. Sykes, Manager, Division of Policy, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219, telephone (804) 786-7958, FAX (804) 786-1680 or e-mail psykes@dmass.state.va.us.

VA.R. Doc. No. R02-165; Filed April 29, 2002, 2:24 p.m.

STATE BOARD FOR MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007 that the State Mental Health, Mental Retardation and Substance Abuse Services Board intends to consider amending regulations entitled: **12 VAC 35-180. Regulations to Assure the Protection of Participants in Human Research.** The purpose of the proposed action is to update the definitions to be consistent with the current Code of Virginia. Other revisions will be made to comply with the requirements of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable federal regulations, as necessary.

The agency intends to hold a public hearing on the proposed regulation after publication in the Virginia Register.

Statutory Authority: §§ 37.1-10 and 37.1-24.01 of the Code of Virginia.

Public comments may be submitted until May 24, 2002.

Contact: Wendy V. Brown, Policy Analyst, Department of Mental Health, Mental Retardation and Substance Abuse Services, P.O. Box 1797, Richmond, VA 23218-1797, telephone (804) 225-2252, FAX (804) 371-0092, e-mail wbrown@dmhmrsas.state.va.us.

VA.R. Doc. No. R02-153; Filed March 27, 2002, 10:12 a.m.

TITLE 13. HOUSING

BOARD OF HOUSING AND COMMUNITY DEVELOPMENT

† Notice of Intended Regulation Action

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Board of Housing and Community Development intends to consider amending regulations entitled: **13 VAC 5-21. Virginia Certifications Standards.** The purpose of the proposed action is to initiate a review and reevaluation of the regulation to determine if it should be continued, amended, or terminated, and to consider amending the regulation by adopting and incorporating updated text to comport with the Virginia Administrative Code formatting and to put before the public proposed changes submitted to the board.

The agency intends to hold a public hearing on the proposed action after publication in the Virginia Register.

Statutory Authority: § 36-137 of the Code of Virginia.

Public comments may be submitted until June 21, 2002.

Contact: George W. Rickman, Jr., Regulatory Coordinator, Department of Housing and Community Development, 501 N. 2nd St., Richmond, VA 23219-1321, telephone (804) 371-7150, FAX (804) 371-7092 or e-mail grickman@dhcd.state.va.us.

VA.R. Doc. No. R02-169; Filed April 30, 2002, 11:57 a.m.

† Withdrawal of Notice of Intended Regulatory Action

Notice is hereby given that the Department of Housing and Community Development has WITHDRAWN the Notice of Intended Regulatory Action for **13 VAC 5-31. Virginia Amusement Device Regulations**, which was published in 14:22 VA.R. 3047 July 20, 1998.

Contact: George W. Rickman, Jr., Regulatory Coordinator, Department of Housing and Community Development, 501 N. 2nd St., Richmond, VA 23219-1321, telephone (804) 371-7150, FAX (804) 371-7092 or e-mail grickman@dhcd.state.va.us.

VA.R. Doc. No. R98-271; Filed May 3, 2002, 4:35 p.m.

† Notice of Intended Regulation Action

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Board of Housing and Community Development intends to consider amending regulations entitled: **13 VAC 5-31. Virginia Amusement Device Regulations.** The purpose of the proposed action is to initiate a review and reevaluation of the regulation to determine if it should be continued, amended, or terminated, and to consider amending the regulation by incorporating by reference updated standards of the American Society for Testing and

Notices of Intended Regulatory Action

Materials (ASTM) for the regulation of amusement devices. Also, proposed changes submitted to the board by the Virginia Amusement Device Technical Advisory Committee will be considered.

Statutory Authority: § 36-98.3 of the Code of Virginia.

Public comments may be submitted until June 21, 2002.

Contact: George W. Rickman, Jr., Regulatory Coordinator, Department of Housing and Community Development, 501 N. 2nd St., Richmond, VA 23219-1321, telephone (804) 371-7150, FAX (804) 371-7092 or e-mail grickman@dhcd.state.va.us.

VA.R. Doc. No. R02-171; Filed April 30, 2002, 11:56 a.m.

† Notice of Intended Regulation Action

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Board of Housing and Community Development intends to consider amending regulations entitled: **13 VAC 5-51. Virginia Statewide Fire Prevention Code**. The purpose of the proposed action is to initiate a review and reevaluation of the regulation to determine if it should be continued, amended, or terminated, and to consider amending the regulation by adopting and incorporating by reference the International Code Council's (ICC) International Fire Code/2000 and to put before the public proposed changes submitted to the board.

The agency intends to hold a public hearing on the proposed action after publication in the Virginia Register.

Statutory Authority: § 27-97 of the Code of Virginia.

Public comments may be submitted until June 21, 2002.

Contact: George W. Rickman, Jr., Regulatory Coordinator, Department of Housing and Community Development, 501 N. 2nd St., Richmond, VA 23219-1321, telephone (804) 371-7150, FAX (804) 371-7092 or e-mail grickman@dhcd.state.va.us.

VA.R. Doc. No. R02-172; Filed April 30, 2002, 11:57 a.m.

† Notice of Intended Regulation Action

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Board of Housing and Community Development intends to consider amending regulations entitled: **13 VAC 5-61. Virginia Uniform Statewide Building Code**. The purpose of the proposed action is to initiate a review and reevaluation of the regulation to determine if it should be continued, amended, or terminated, and to consider amending the regulation by adopting and incorporating by reference the International Code Council's (ICC), International Building Code/2000 and to put before the public proposed changes submitted to the board.

The agency intends to hold a public hearing on the proposed action after publication in the Virginia Register.

Statutory Authority: § 36-98 of the Code of Virginia.

Public comments may be submitted until June 21, 2002.

Contact: George W. Rickman, Jr., Regulatory Coordinator, Department of Housing and Community Development, 501 N. 2nd St., Richmond, VA 23219-1321, telephone (804) 371-7150, FAX (804) 371-7092 or e-mail grickman@dhcd.state.va.us.

VA.R. Doc. No. R02-170; Filed April 30, 2002, 11:57 a.m.

† Notice of Intended Regulation Action

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Board of Housing and Community Development intends to consider amending regulations entitled: **13 VAC 5-80. Standards Governing Operation of Individual and Regional Code Academies/1990**. The purpose of the proposed action is to initiate a review and reevaluation of the regulation to determine if it should be continued, amended, or terminated, and to consider amending the regulation by adopting and incorporating updated text to comport with the Virginia Administrative Code formatting and to put before the public proposed changes submitted to the board.

The agency intends to hold a public hearing on the proposed action after publication in the Virginia Register.

Statutory Authority: §§ 36-137 and 36-139 of the Code of Virginia.

Public comments may be submitted until June 21, 2002.

Contact: George W. Rickman, Jr., Regulatory Coordinator, Department of Housing and Community Development, 501 N. 2nd St., Richmond, VA 23219-1321, telephone (804) 371-7150, FAX (804) 371-7092 or e-mail grickman@dhcd.state.va.us.

VA.R. Doc. No. R02-168; Filed April 30, 2002, 11:57 a.m.

† Withdrawal of Notice of Intended Regulatory Action

Notice is hereby given that the Department of Housing and Community Development has WITHDRAWN the Notice of Intended Regulatory Action for **13 VAC 5-91. Virginia Industrialized Building Safety Regulations**, which was published in 14:23 VA.R. 3379 August 3, 1998.

Contact: George W. Rickman, Jr., Regulatory Coordinator, Department of Housing and Community Development, 501 N. 2nd St., Richmond, VA 23219-1321, telephone (804) 371-7150, FAX (804) 371-7092 or e-mail grickman@dhcd.state.va.us.

VA.R. Doc. No. R98-297; Filed May 3, 2002, 4:35 p.m.

† Notice of Intended Regulation Action

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Board of Housing and Community Development intends to consider amending regulations entitled: **13 VAC 5-91. Virginia Industrialized Building Safety Regulations**. The purpose of the proposed action is to initiate a review and reevaluation of the regulation to

Notices of Intended Regulatory Action

determine if it should be continued, amended, or terminated, and to consider amending the regulation by adopting and incorporating by reference the International Code Council's (ICC), International Building Code/2000 and to put before the public proposed changes submitted to the board.

The agency intends to hold a public hearing on the proposed action after publication in the Virginia Register.

Statutory Authority: § 36-73 of the Code of Virginia.

Public comments may be submitted until June 21, 2002.

Contact: George W. Rickman, Jr., Regulatory Coordinator, Department of Housing and Community Development, 501 N. 2nd St., Richmond, VA 23219-1321, telephone (804) 371-7150, FAX (804) 371-7092 or e-mail grickman@dhcd.state.va.us.

VA.R. Doc. No. R02-173; Filed April 30, 2002, 11:56 a.m.

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

BOARD OF DENTISTRY

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Board of Dentistry intends to consider amending regulations entitled: **18 VAC 60-20. Regulations Governing the Practice of Dentistry and Dental Hygiene.** The purpose of the proposed action is to amend regulations pursuant to recommendations of a periodic review, including but not limited to updates to certain requirements and terminology, clarification of requirements, and an expanded access to Virginia licensure for persons who are licensed in other states and hold board certification in a specialty area of dentistry approved by the American Dental Association Commission on Dental Accreditation. The board will also consider modifying and adding requirements and qualifications for administration of various forms of analgesia, sedation and anesthesia as minimally necessary to ensure public safety. It will consider an amendment to specify that dental education must be in an accredited program of at least 24 months in duration.

The agency intends to hold a public hearing on the proposed regulation after publication.

Statutory Authority: § 54.1-2400 and Chapter 27 (§ 54.1-2700 et seq.) of Title 54.1 of the Code of Virginia.

Public comments may be submitted until June 19, 2002.

Contact: Sandra Reen, Executive Director, Board of Dentistry, 6606 W. Broad St., Richmond, VA 23230-1717, telephone (804) 662-9906, FAX (804) 662-9943 or e-mail sandra.reen@dhp.state.va.us.

VA.R. Doc. No. R02-176; Filed May 1, 2002, 10:41 a.m.

BOARD OF MEDICINE

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Board of Medicine intends to consider amending regulations entitled: **18 VAC 85-20. Regulations Governing the Practice of Medicine, Osteopathy, Podiatry and Chiropractic.** The purpose of the proposed action is to eliminate unnecessary provisions of the regulations, clarify provisions that have raised questions for licensees or the public, especially the rules on advertising, and specify the use of the term "active practice."

The agency intends to hold a public hearing on the proposed action after publication in the Virginia Register.

Statutory Authority: § 54.1-2400 and Chapter 29 (§ 54.1-2900 et seq.) of Title 54.1 of the Code of Virginia.

Public comments may be submitted until June 19, 2002.

Contact: William Harp, M.D., Executive Director, Board of Medicine, 6606 W. Broad St., Richmond, VA 23230-1717, telephone (804) 662-9908, FAX (804) 662-9943 or e-mail william.harp@dhp.state.va.us.

VA.R. Doc. No. R02-177; Filed May 1, 2002, 10:41 a.m.

TITLE 22. SOCIAL SERVICES

STATE BOARD OF SOCIAL SERVICES

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the State Board of Social Services intends to consider repealing regulations entitled: **22 VAC 40-110. Minimum Standards for Licensed Family Day Homes** and promulgating regulations entitled: **22 VAC 40-111. Minimum Standards for Licensed Family Day Homes.** The purpose of the proposed action is to incorporate the repealed Minimum Standards for Licensed Family Day Homes (22 VAC 40-110) into a proposed regulation entitled Minimum Standards for Licensed Family Day Homes (22 VAC 40-111). The text will be reorganized and reworded for clarity as requested by regional licensing staff, child care advocates, and licensed family day home providers. This action is taken as a result of the department's periodic review of regulations.

The agency intends to hold a public hearing on the proposed regulations after publication in the Virginia Register.

Statutory Authority: §§ 63.1-25 and 63.1-202 of the Code of Virginia.

Public comments may be submitted until May 22, 2002.

Contact: Doris Sherrod, Human Services Program Consultant, Division of Licensing Programs, Department of

Notices of Intended Regulatory Action

Social Services, 730 E. Broad St., 7th Floor, Richmond, VA 23219, telephone (804) 692-1748, FAX (804) 692-2370 or e-mail dss7@email1.dss.state.va.us.

VA.R. Doc. Nos. R02-149 and R02-150; Filed March 21, 2002, 1:41 p.m.

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the State Board of Social Services intends to consider repealing regulations entitled: **22 VAC 40-220. Agency Placement Adoption-Guiding Principles**. The purpose of the proposed action is to repeal 22 VAC 40-220, which addresses agency adoption guiding principles. Provisions of the regulation conflict with current federal law, and another is mandated by the Code of Virginia. The remainder addresses suggested practices, rather than statute.

The agency does not intend to hold a public hearing on the proposed regulation after publication in the Virginia Register.

Statutory Authority: §§ 63.1-25 and 63.1-56 of the Code of Virginia.

Public comments may be submitted until May 22, 2002.

Contact: Karin Clark, Adoption Program Consultant, Department of Social Services, 730 E. Broad St., 7th Floor, Richmond, VA 23219, telephone (804) 692-1251, FAX (804) 692-1284 or e-mail kac900@email1.state.va.us.

VA.R. Doc. No. R02-152; Filed March 21, 2002, 1:42 p.m.

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the State Board of Social Services intends to consider adopting regulations entitled: **22 VAC 40-375. Economic and Employment Improvement Program for Disadvantaged Persons**. The purpose of the proposed action is to adopt regulations to improve employability of disadvantaged persons through education and training. The program also extends eligibility for education and job training services to certain other hard-to-employ persons. The goal of the program is to promote self-sufficiency enabling participants to move from minimum wage jobs to college and to employment and occupations that will facilitate career development and economic independence.

The agency does not intend to hold a public hearing on the proposed regulation after publication in the Virginia Register.

Statutory Authority: § 63.1-133.57 of the Code of Virginia.

Public comments may be submitted until May 22, 2002.

Contact: William Stith, Program Coordinator, Division of Community Programs, Department of Social Services, 730 E. Broad St., 7th Floor, Richmond, VA 23219, telephone (804) 692-0382, FAX (804) 225-2202 or e-mail wgs2@email1.dss.state.va.us.

VA.R. Doc. No. R02-151; Filed March 20, 2002, 1:41 p.m.



PROPOSED REGULATIONS

For information concerning Proposed Regulations, see Information Page.

Symbol Key

Roman type indicates existing text of regulations. *Italic type* indicates proposed new text.
Language which has been stricken indicates proposed text for deletion.

TITLE 12. HEALTH

STATE BOARD OF HEALTH

Title of Regulation: 12 VAC 5-220. Virginia Medical Care Facilities Certificate of Public Need Rules and Regulations (amending 12 VAC 5-220-10, 12 VAC 5-220-90, 12 VAC 5-220-105, 12 VAC 5-220-160, 12 VAC 5-220-180, 12 VAC 5-220-200, 12 VAC 5-220-230, 12 VAC 5-220-270, 12 VAC 5-220-280, 12 VAC 5-220-355, 12 VAC 5-220-385, 12 VAC 5-220-420, and 12 VAC 5-220-470; repealing 12 VAC 5-220-150).

12 VAC 5-230. State Medical Facilities Plan (amending 12 VAC 5-230-10 and 12 VAC 5-230-20).

12 VAC 5-240. State Medical Facilities Plan: General Acute Care Services (amending 12 VAC 5-240-10, 12 VAC 5-240-20, and 12 VAC 5-240-30).

12 VAC 5-250. State Medical Facilities Plan: Perinatal Services (amending 12 VAC 5-250-30).

12 VAC 5-260. State Medical Facilities Plan: Cardiac Services (amending 12 VAC 5-260-30, 12 VAC 5-260-40, 12 VAC 5-260-80, and 12 VAC 5-260-100).

12 VAC 5-270. State Medical Facilities Plan: General Surgical Services (amending 12 VAC 5-270-30 and 12 VAC 5-270-40).

12 VAC 5-280. State Medical Facilities Plan: Organ Transplantation Services (amending 12 VAC 5-280-10, 12 VAC 5-280-30, and 12 VAC 5-280-70).

12 VAC 5-290. State Medical Facilities Plan: Psychiatric and Substance Abuse Treatment Services (amending 12 VAC 5-290-10 and 12 VAC 5-290-30).

12 VAC 5-300. State Medical Facilities Plan: Mental Retardation Services (amending 12 VAC 5-300-30).

12 VAC 5-310. State Medical Facilities Plan: Medical Rehabilitation Services (amending 12 VAC 5-310-30).

12 VAC 5-320. State Medical Facilities Plan: Diagnostic Imaging Services (amending 12 VAC 5-320-50, 12 VAC 5-320-150, and 12 VAC 5-320-430).

12 VAC 5-340. State Medical Facilities Plan: Radiation Therapy Services (amending 12 VAC 5-340-30).

12 VAC 5-360. State Medical Facilities Plan: Nursing Home Services (amending 12 VAC 5-360-30 and 12 VAC 5-360-40).

Statutory Authority: §§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Public Hearing Date: N/A — Public comments may be submitted until July 22, 2002.

(See Calendar of Events section for additional information)

Agency Contact: Carrie Eddy, Policy Analyst Senior, Center for Quality Health Care Services and Consumer Protection, Department of Health, 3600 W. Broad Street, Suite 216,

Richmond, VA 23230, telephone (804) 367-2157, FAX (804) 367-2149, or e-mail ceddy@vdh.state.va.us.

Basis: Section 32.1-12 of the Code of Virginia authorizes the board to may make, adopt, and promulgate regulations and provide for reasonable variances and exemptions therefrom as may be necessary to carry out the provisions of Title 32.1 of the Code of Virginia and other laws of the Commonwealth administered by it, the commissioner or the department.

Section 32.1-102.2 of the Code of Virginia requires the board to promulgate regulations that are consistent with Article 1.1:1 (§ 32.1-102.1 et seq.) of Chapter 4 of Title 32.1 of the Code of Virginia, which relates to medical care facilities certificate of public need.

Purpose: The Virginia Medical Care Facilities Certificate of Public Need program was designed to promote comprehensive health planning to meet the health care needs of the public, while avoiding duplication of specified medical care services. The proposed amendments ensure timely decision making regarding those services requiring a COPN and address the issue of barriers to service delivery in rural areas. In addition, Virginia's liver transplantation volume criterion does not meet nationally recommended transplantation volumes to maximum survival rates and professional competency. Therefore, the criterion is being amended.

These amendments to the Certificate of Public Need Rules and Regulations and the State Medical Facilities Plan address service availability and delivery and ensure better access to medical care for Virginia's citizens.

Substance: The amendments to the COPN regulation: (i) address the special needs of rural localities when making COPN decisions, (ii) reduce the scope of the regulatory program, (iii) mandate an annual report on program activities, (iv) simplify the fee schedule, and (v) modify the response time by which decisions on disputed projects must be issued. The essence of the amendments reduces the burden imposed by the COPN program on persons subject to the regulation.

There are only two topical changes made to the SMFP: (i) consideration of the barriers to health care access for populations in rural areas when making COPN decisions and (ii) increasing the minimum number of transplantation procedures from 12 to 20 to ensure successful liver transplants.

Issues: The primary advantage of the amendments is an overall reduction in the scope of the COPN program. Other advantages include a simplified fee structure, revised project review deadlines to ensure timely decision making, and inclusion of rural localities in the decision making process. Amendments to selected sections of the SMFP establish criteria for determining need in rural areas, giving due consideration to distinct and unique geographic, cultural, transportation, and other barriers to access to care, and

provide for weighted calculations of need based on the barriers to health care access in rural areas.

The organ transplantation services component of the SMFP is intended to provide a rational basis for considering the public need for new or expanded organ transplantation services in Virginia. The health, safety, and welfare of Virginia's citizens will be enhanced by assuring that the standards used in review of proposed organ transplantation projects reflect the most current national experience in transplantation program performance. This is a highly specialized medical service that only a few large hospitals have or will seek to offer, based on the available technology in the field.

The standards for approval of such services are intended to require new programs to provide a sufficient number of transplants to help ensure maximum survival rates, professional competence, and economies of scope in operations. An article in the New England Journal of Medicine, on December 30, 1999 (vol. 341, no. 27, pp. 2049-53) reported that: "as a group, liver-transplantation centers in the United States that perform 20 or fewer transplantations per year have mortality rates that are significantly higher than those at centers that perform more than 20 transplantations per year." Currently, the SMFP calls for only 12 procedures per year, far below the standard needed to assure successful outcomes. Therefore, the department, as the state's advocate for public health, safety, and welfare, has determined it is necessary to increase the state's criteria to 20 procedures per year.

There are no disadvantages to the public, the Commonwealth, or businesses as a result of these amendments to selected sections of the COPN regulation and SMFP.

Department of Planning and Budget's Economic Impact Analysis: The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007 G of the Administrative Process Act and Executive Order Number 25 (98). Section 2.2-4007 G requires that such economic impact analyses include, but need not be limited to, the projected number of businesses or other entities to whom the regulation would apply, the identity of any localities and types of businesses or other entities particularly affected, the projected number of persons and employment positions to be affected, the projected costs to affected businesses or entities to implement or comply with the regulation, and the impact on the use and value of private property. The analysis presented below represents DPB's best estimate of these economic impacts.

Summary of the proposed regulation. Pursuant to changes in the Code of Virginia (Code) as a result of the 1999 and 2000 sessions of the General Assembly, the Board of Health (board) proposes several changes to the regulations. The proposed changes include: (i) increased fees for Certificate of Public Need (COPN) applications, (ii) elimination of the requirement that a COPN be obtained for the replacement of medical equipment, (iii) requiring registration for the replacement of medical equipment, (iv) elimination of the requirement that nuclear cardiac imaging equipment be subject to the COPN, (v) addition of the needs of rural populations as a factor for consideration in granting a COPN, (vi) the Virginia Department of Health's (VDH) review period

for COPN applications is increased from 120 days to 190 days, (vii) COPN applications are approved by default if VDH does not meet set deadlines, (viii) language that allows for informal fact finding conferences to be scheduled earlier, and (ix) an increase in the minimum number of liver transplants per year required for program approval. Emergency regulations reflecting these requirements became effective on January 3, 2000, and expired 12 months later. The board proposes to amend the permanent regulations to reflect the changes in the Code.

Estimated economic impact. Pursuant to the Code, application fees for the COPN are set at "one percent of the proposed expenditure for the project, but not less than \$1,000 and no more than \$20,000." The current regulations have the following COPN application fee schedule:

| For Projects with Capital Expenditures from ... | The Application Fee is ... |
|---|--|
| \$0 up to and including \$1,000,000 | The greater of 1% of the Capital Expenditure or \$1,000 |
| \$1,000,001 up to and including \$2,000,000 | \$10,000 plus 0.25% of the Capital Expenditure above \$1,000,000 |
| \$2,000,001 up to and including \$3,000,000 | \$12,500 plus 0.25% of the Capital Expenditure above \$2,000,000 |
| \$3,000,001 up to and including \$4,000,000 | \$15,000 plus 0.25% of the Capital Expenditure above \$3,000,000 |
| \$4,000,001 up to and including \$5,000,000 | \$17,500 plus 0.25% of the Capital Expenditure above \$4,000,000 |
| \$5,000,001 or more | \$20,000 |

Thus, fees for COPN applicants with projects with capital expenditures greater than \$1,000,000, but less than \$5,000,000, will increase. For example, the application fee for a capital project costing 2,000,000 would be \$20,000 under the proposed regulations, while it is \$12,500 under the current regulations. According to VDH, application fees are used to cover costs in operating the COPN program for both the agency and the five regional health-planning agencies. The costs of the higher fees are clear. The benefits of the higher fees are less clear and are related to the value of requiring a COPN.

There are essentially three arguments in favor of requiring a COPN. First, it is argued that adding medical service capacity creates its own demand for medical services, which drives up medical costs. For example, say patients need to wait days or weeks to get access to a certain type of medical equipment. If a hospital acquires more of that type of equipment, more of the services associated with that type of equipment could be performed in a given period time, thus driving up costs associated with the services related to that equipment. Thus, limiting the supply of medical services may help in slowing the rise in medical costs. In reality, though, unmet demand already exists in this example; the acquisition of the additional equipment adds supply to meet already existing demand. This argument boils down to the rationing of services to save on costs. The net benefits of rationing medical services and

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potentially limiting total medical costs through the use of COPNs are unclear. It is not known whether the benefits of potential cost savings associated rationing medical services and potentially limiting total medical costs through the use of COPNs exceed the costs to patients of reduced medical services. Additionally, there may be more efficient methods of rationing. Second, the threat of a disapproved COPN application can be used to get medical facilities to agree to serve a minimum number of charity care patients or money-losing services that are desired by the public. The provision of these services does provide public benefit, but it is not clear whether it is always equitable and efficient to require medical facilities to absorb these costs. Third, according to VDH, some services and patients are inherently net money losers (emergency rooms, ICUs, indigent, etc.) and need to be cross-subsidized by profitable services (ambulatory surgery, MRIs, CTs, etc.) for hospitals to remain financially viable. If, for example, independent ambulatory surgery centers were permitted to form without restrictions in the vicinity of full-service hospitals, then the full-service hospitals would be put at a competitive disadvantage; unlike hospitals, the independent ambulatory surgery centers could operate without having to pay cross subsidies to maintain money-losing services needed by the public. Restricting the services offered or requiring additional money-losing services for practices such as an independent ambulatory surgery center may seem equitable compared with hospitals, and will likely provide public benefit, but may also discourage the formation of valuable new practices. Thus, the net benefit of requiring a COPN is unclear.

The Code and proposed regulations no longer require that medical facilities obtain a COPN for the replacement of medical equipment. Instead, the replacement equipment would need to be registered. This change represents a significant reduction in fees, time, and labor costs. According to VDH, the registration form has no fee and takes at most half an hour to fill out. The COPN application has a fee as described in the above table, and takes at least 40 hours to fill out.¹ Prior to the Code change, in practice, VDH did not usually require concessions (increased charitable case load, for example) or altered plans for COPN approval on replacement equipment. This change likely produces a net benefit since the cost savings are significant, while the actions of the medical facilities are not substantially altered.

Eliminating the requirement that nuclear cardiac imaging be subject to a COPN will save medical facilities fees and the time and labor associated with preparing a COPN. The fees saved depend on the project cost as described in the table above. According to VDH, it takes at least 40 hours of labor to file a COPN application. Prior to the change in the Code, VDH did require concessions (increased charitable case load, for example) or altered plans for COPN approval on new nuclear cardiac imaging equipment. Thus, by eliminating the COPN requirement for new nuclear cardiac imaging, the benefits and costs associated with concessions and altered plans made by medical facilities in order to a COPN are eliminated as well.

The regulations include numerous factors for consideration when VDH decides whether or not to grant a COPN to an applicant. The Code and proposed regulations add the needs of rural populations as a factor for consideration in granting a COPN. According to VDH, there is no set formula in determining approval. Thus, the impact of adding the needs of rural populations as a factor will depend on how much the agency chooses to consider it when making their approval decision. To the extent that it is used, it may have a positive impact on the amount of medical services offered in rural areas.

VDH is allotted 190 days to review COPN applications under the proposed regulations, versus 120 days under the current regulations. But, under the current regulations there are no repercussions for not meeting the deadline. According to VDH, it has commonly taken more than 120 days to process COPN applications, and on occasions prior to the implementation of the emergency regulations, taken more than 190 days. Under the proposed regulations, the COPN applications are automatically approved if VDH does not meet their deadline. Thus, in contrast to the previous processing deadline, the proposed 190-day deadline will be effective in practice. This change will be net beneficial in that it will eliminate the small number of occasions where a COPN application takes longer than 190 days to process.

The proposed regulations also allow informal fact finding conferences to be scheduled earlier in the COPN application process than in the current regulations. This may on some occasions shorten the COPN application process by a matter of days. A shorter application process would allow medical facilities that gain COPN approval to use their capital equipment sooner. Since this proposed change has no apparent costs, it will produce a net benefit.

The Code and proposed regulations also increase the minimum number of liver transplantations performed by a medical facility per year in order for the medical facility to be approved to perform liver transplantations from 12 procedures per year to 20 procedures per year. This change was prompted by research published in the *New England Journal of Medicine*² that found that "as a group, liver-transplantation centers in the United States that perform 20 or fewer transplantations per year have mortality rates that are significantly higher than those at centers that perform more than 20 transplantations per year." The study did control for attributes other than transplantation volume. This change may prevent some medical facilities from offering liver transplantations that otherwise would have; but, given the finding concerning differences in mortality rates between facilities with less than or greater than 20 procedures per year, it is probable that this change produces a net benefit.

Businesses and entities affected. The proposed amendments will affect the 265 licensed nursing facilities, 123 licensed hospitals in Virginia, other medical facilities and practices,

¹ Source: VDH

² Edwards, Erick B., Roberts, John P., McBride, Maureen A., Schulak, James A., and Lawrence G. Hunsicker, "The Effect of the Volume of Procedures at Transplantation Centers on Mortality After Liver Transplantation," *The New England Journal of Medicine*, December 30, 1999 – Vol. 341, No. 27.

rural citizens, indigent patients, and potentially liver transplantation patients.

Localities particularly affected. The proposed amendments potentially affect localities throughout the Commonwealth.

Projected impact on employment. At least one part position at VDH is no longer necessary due to the elimination of the requirement of a COPN for replacement equipment and nuclear cardiac imaging equipment. Also, fewer labor hours are required by medical facilities in the preparation of COPN applications due to the elimination of the requirement of a COPN for replacement equipment and nuclear cardiac imaging equipment.

Effects on the use and value of private property. The value of medical facilities acquiring relative large dollar amounts of new non-nuclear cardiac imaging equipment and relative small amounts of replacement and nuclear cardiac imaging equipment will likely decrease in value by a small amount due to the higher COPN application fees on new non-nuclear cardiac imaging equipment. The value of medical facilities acquiring relative small dollar amounts of new non-nuclear cardiac imaging equipment and relative large amounts of replacement and nuclear cardiac imaging equipment will likely increase in value by a small amount due to the elimination of application fees on replacement and nuclear cardiac imaging equipment. Also the value of potential medical facilities that perform fewer than 20 liver transplantations per year may decrease, and the value of medical facilities that perform greater than 20 liver transplantations per year may increase due to the change in minimum number of procedures per year.

Agency's Response to the Department of Planning and Budget's Economic Impact Analysis: The Department of Health concurs with the economic impact assessment prepared by the Department of Planning and Budget regarding the COPN Regulations and the SMFP.

Summary:

The proposed amendments (i) increase fees for Certificate of Public Need (COPN) applications, (ii) require registration for the replacement of medical equipment and eliminate the requirement that a COPN be obtained for the replacement of medical equipment, (iii) eliminate the requirement that nuclear cardiac imaging equipment be subject to the COPN, (iv) add the needs of rural populations as a factor for consideration in granting a COPN, (v) increase the department's review period for COPN applications from 120 days to 190 days, (vi) provide that COPN applications are approved by default if the department does not meet set deadlines, (viii) allows earlier scheduling of informal fact-finding conferences, and (ix) increases the minimum number of liver transplants per year required for program approval.

12 VAC 5-220-10. Definitions.

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise:

"*Acquisition*" means an expenditure of \$600,000 or more that changes the ownership of a medical care facility. It shall also

include the donation or lease of a medical care facility. An acquisition of a medical care facility shall not include a capital expenditure involving the purchase of stock. See 12 VAC 5-220-120.

"*Amendment*" means any modification to an application which is made following the public hearing and prior to the issuance of a certificate and includes those factors that constitute a significant change as defined in this chapter. An amendment shall not include a modification to an application which serves to reduce the scope of a project.

"*Applicant*" means the owner of an existing medical care facility or the sponsor of a proposed medical care facility project submitting an application for a certificate of public need.

"*Application*" means a prescribed format for the presentation of data and information deemed necessary by the board to determine a public need for a medical care facility project.

"*Application fees*" means fees required for a project application and application for a significant change. Fees shall not exceed the lesser of 1.0% of the proposed capital expenditure or cost increase for the project or \$20,000.

"*Board*" means the State Board of Health.

"*Capital expenditure*" means any expenditure by or in behalf of a medical care facility which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance. Such expenditure shall also include a series of related expenditures during a 12-month period or a financial obligation or a series of related financial obligations made during a 12-month period by or in behalf of a medical care facility. Capital expenditures need not be made by a medical care facility so long as they are made in behalf of a medical care facility by any person. See definition of "person."

"*Certificate of public need*" means a document which legally authorizes a medical care facility project as defined herein and which is issued by the commissioner to the owner of such project.

"*Clinical health service*" means a single diagnostic, therapeutic, rehabilitative, preventive or palliative procedure or a series of such procedures that may be separately identified for billing and accounting purposes.

"*Commissioner*" means the State Health Commissioner who has authority to make a determination respecting the issuance or revocation of a certificate.

"*Competing applications*" means applications for the same or similar services and facilities which are proposed for the same planning district or medical service area and which are in the same review cycle. See 12 VAC 5-220-220.

"*Completion*" means conclusion of construction activities necessary for substantial performance of the contract.

"*Construction*" means the building of a new medical facility or the expansion, remodeling, or alteration of an existing medical care facility.

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"Construction, initiation of" means that a project shall be considered under construction for the purpose of certificate extension determinations upon the presentation of evidence by the owner of: (i) a signed construction contract; (ii) the completion of short term financing and a commitment for long term (permanent) financing when applicable; (iii) the completion of predevelopment site work; and (iv) the completion of building foundations.

"Date of issuance" means the date of the commissioner's decision awarding a certificate of public need.

"Department" means the State Department of Health.

"Designated medically underserved areas" means (i) areas designated as medically underserved areas pursuant to § 32.1-122.5 of the Code of Virginia; (ii) federally designated Medically Underserved Areas (MUA); or (iii) federally designated Health Professional Shortage Areas (HPSA).

"Ex parte" means any meeting which takes place between (i) any person acting in behalf of the applicant or holder of a certificate of public need or any person opposed to the issuance or in favor of the revocation of a certificate of public need and (ii) any person who has authority in the department to make a decision respecting the issuance or revocation of a certificate of public need for which the department has not provided 10 ~~days~~ ^{days} written notification to opposing parties of the time and place of such meeting. An ex parte contact shall not include a meeting between the persons identified in (i) and staff of the department.

"Gamma knife surgery" means stereotactic radiosurgery, where stereotactic radiosurgery is the noninvasive therapeutic procedure performed by directing radiant energy beams from any source at a treatment target in the head to produce tissue destruction. See definition of "project."

"Health planning region" means a contiguous geographical area of the Commonwealth with a population base of at least 500,000 persons which is characterized by the availability of multiple levels of medical care services, reasonable travel time for tertiary care, and congruence with planning districts.

"Informal fact-finding conference" means a conference held pursuant to § ~~9-6.14-14~~ 2.2-4019 of the Code of Virginia.

"Inpatient beds" means accommodations within a medical care facility with continuous support services (such as food, laundry, housekeeping) and staff to provide health or health-related services to patients who generally remain in the medical care facility in excess of 24 hours. Such accommodations are known by varying nomenclatures including but not limited to: nursing beds, intensive care beds, minimal or self care beds, isolation beds, hospice beds, observation beds equipped and staffed for overnight use, and obstetric, medical, surgical, psychiatric, substance abuse, medical rehabilitation and pediatric beds, including pediatric bassinets and incubators. Bassinets and incubators in a maternity department and beds located in labor or birthing rooms, recovery rooms, emergency rooms, preparation or anesthesia inductor rooms, diagnostic or treatment procedures rooms, or on-call staff rooms are excluded from this definition.

"Medical care facility" means any institution, place, building, or agency, at a single site, whether or not licensed or required to be licensed by the board or the State Mental Health, Mental Retardation and Substance Abuse Services Board, whether operated for profit or nonprofit and whether privately owned or operated or owned or operated by a local governmental unit, (i) by or in which facilities are maintained, furnished, conducted, operated, or offered for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition, whether medical or surgical, of two or more nonrelated mentally or physically sick or injured persons, or for the care of two or more nonrelated persons requiring or receiving medical, surgical, or nursing attention or services as acute, chronic, convalescent, aged, physically disabled, or crippled or (ii) which is the recipient of reimbursements from third party health insurance programs or prepaid medical service plans. For purposes of this chapter, only the following medical care facility classifications shall be subject to review:

1. General hospitals.
2. Sanitariums.
3. Nursing homes.
4. Intermediate care facilities.
5. Extended care facilities.
6. Mental hospitals.
7. Mental retardation facilities.
8. Psychiatric hospitals and intermediate care facilities established primarily for the medical, psychiatric or psychological treatment and rehabilitation of alcoholics or drug addicts.
9. Specialized centers or clinics or that portion of a physician's office developed for the provision of outpatient or ambulatory surgery, cardiac catheterization, computed tomographic (CT) scanning, gamma knife surgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI), positron emission tomographic (PET) scanning, radiation therapy, nuclear medicine imaging, or such other specialty services as may be designated by the board by regulation.
10. Rehabilitation hospitals.
11. Any facility licensed as a hospital.

For purposes of this chapter, the following medical care facility classifications shall not be subject to review:

1. Any facility of the Department of Mental Health, Mental Retardation and Substance Abuse Services.
2. Any nonhospital substance abuse residential treatment program operated by or contracted primarily for the use of a community services board under the Department of Mental Health, Mental Retardation and Substance Abuse Services Comprehensive Plan.
3. Any physician's office, except that portion of the physician's office which is described in subdivision 9 of the definition of "medical care facility."

4. The Woodrow Wilson Rehabilitation Center of the Virginia Department of Rehabilitative Services.

"Medical service area" means the geographic territory from which at least 75% of patients come or are expected to come to existing or proposed medical care facilities, the delineation of which is based on such factors as population characteristics, natural geographic boundaries, and transportation and trade patterns, and all parts of which are reasonably accessible to existing or proposed medical care facilities.

"Modernization" means the alteration, repair, remodeling, replacement or renovation of an existing medical care facility or any part thereto, including that which is incident to the initial and subsequent installation of equipment in a medical care facility. See definition of "construction."

"Operating expenditure" means any expenditure by or in behalf of a medical care facility which, under generally accepted accounting principles, is properly chargeable as an expense of operation and maintenance and is not a capital expenditure.

"Operator" means any person having designated responsibility and legal authority from the owner to administer and manage a medical care facility. See definition of "owner."

"Other plans" means any plan(s) which is formally adopted by an official state agency or regional health planning agency and which provides for the orderly planning and development of medical care facilities and services and which is not otherwise defined in this chapter.

"Owner" means any person who has legal responsibility and authority to construct, renovate or equip or otherwise control a medical care facility as defined herein.

"Person" means an individual, corporation, partnership, association or any other legal entity, whether governmental or private. Such person may also include the following:

1. The applicant for a certificate of public need;
2. The regional health planning agency for the health planning region in which the proposed project is to be located;
3. Any resident of the geographic area served or to be served by the applicant;
4. Any person who regularly uses health care facilities within the geographic area served or to be served by the applicant;
5. Any facility or health maintenance organization (HMO) established under § 38.2-4300 et seq. of the Code of Virginia ~~which~~ *that* is located in the health planning region in which the project is proposed and ~~which~~ *that* provides services similar to the services of the medical care facility project under review;
6. Third party payors who provide health care insurance or prepaid coverage to 5.0% or more patients in the health planning region in which the project is proposed to be located; and

7. Any agency which reviews or establishes rates for health care facilities.

"Physician's office" means a place, owned or operated by a licensed physician or group of physicians practicing in any legal form whatsoever, which is designed and equipped solely for the provision of fundamental medical care whether diagnostic, therapeutic, rehabilitative, preventive or palliative to ambulatory patients and which does not participate in cost-based or facility reimbursement from third party health insurance programs or prepaid medical service plans excluding pharmaceuticals and other supplies administered in the office. See definition of "medical care facility."

"Planning district" means a contiguous area within the boundaries established by the Department of Housing and Community Development as set forth in § 15.2-4202 of the Code of Virginia, *except that for purposes of this chapter, Planning District 23 shall be divided into two planning districts: Planning District 20, consisting of the counties of Isle of Wight and Southampton and the cities of Chesapeake, Franklin, Norfolk, Portsmouth, Suffolk and Virginia Beach; and Planning District 21, consisting of the counties of James City and York and the cities of Hampton, Newport News, Poquoson and Williamsburg.*

"Predevelopment site work" means any preliminary activity directed towards preparation of the site prior to the completion of the building foundations. This includes, but is not limited to, soil testing, clearing, grading, extension of utilities and power lines to the site.

"Primary medical care services" means first-contact, whole-person medical and health services delivered by broadly trained, generalist physicians, nurses and other professionals, intended to include, without limitation, obstetrics/gynecology, family practice, internal medicine and pediatrics.

"Progress" means actions which are required in a given period of time to complete a project for which a certificate of public need has been issued. See 12 VAC 5-220-450, Demonstration of progress.

"Project" means:

1. The establishment of a medical care facility. See definition of "medical care facility."
2. An increase in the total number of beds or operating rooms in an existing or authorized medical care facility.
3. Relocation at the same site of 10 beds or 10% of the beds, whichever is less, from one existing physical facility to another in any two-year period; however, a hospital shall not be required to obtain a certificate for the use of 10% of its beds as nursing home beds as provided in § 32.1-132 of the Code of Virginia.
4. The introduction into any existing medical care facility of any new nursing home service such as intermediate care facility services, extended care facility services or skilled nursing facility services except when such medical care facility is an existing nursing home as defined in § 32.1-123 of the Code of Virginia.

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5. The introduction into an existing medical care facility of any new cardiac catheterization, computed tomography (CT), gamma knife surgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI), medical rehabilitation, neonatal special care services, obstetrical services, open heart surgery, positron emission tomographic (PET) scanning, organ or tissue transplant service, radiation therapy, nuclear medicine imaging, psychiatric or substance abuse treatment, or such other specialty clinical services as may be designated by the board by regulation, which the facility has never provided or has not provided in the previous 12 months.

6. The conversion of beds in an existing medical care facility to medical rehabilitation beds or psychiatric beds.

7. The addition ~~or replacement~~ by an existing medical care facility of any medical equipment for the provision of cardiac catheterization, computed tomography (CT), gamma knife surgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI), open heart surgery, positron emission tomographic (PET) scanning, radiation therapy, or other specialized service designated by the board by regulation, ~~except for the replacement of any medical equipment identified in this part which the commissioner has determined to be an emergency in accordance with 12 VAC 5-220-150 or for which it has been determined that a certificate of public need has been previously issued for replacement of the specific equipment according to 12 VAC 5-220-105.~~

8. Any capital expenditure of \$5 million or more, not defined as reviewable in subdivisions 1 through 7 of this definition, by or in behalf of a medical care facility. However, capital expenditures between \$1 million and \$5 million shall be registered with the commissioner.

"Public hearing" means a proceeding conducted by a regional health planning agency at which an applicant for a certificate of public need and members of the public may present oral or written testimony in support or opposition to the application which is the subject of the proceeding and for which a verbatim record is made. See subsection A of 12 VAC 5-220-230.

"Regional health plan" means the regional plan adopted by the regional health planning agency board.

"Regional health planning agency" means the regional agency, including the regional health planning board, its staff and any component thereof, ~~designated by the Virginia Health Planning Board to perform that performs~~ health planning activities within a health planning region.

"Rural" means territory, population, and housing units that are classified as "rural" by the Bureau of the Census of the United States Department of Commerce, Economics and Statistics Administration.

"Schedule for completion" means a timetable which identifies the major activities required to complete a project as identified by the applicant and which is set forth on the certificate of public need. The timetable is used by the commissioner to evaluate the applicant's progress in completing an approved project.

"Significant change" means any alteration, modification or adjustment to a reviewable project for which a certificate of public need has been issued or requested following the public hearing which:

1. Changes the site;
2. Increases the capital expenditure amount authorized by the commissioner on the certificate of public need issued for the project by 10% or more;
3. Changes the service(s) proposed to be offered;
4. Extends the schedule for completion of the project beyond three years (36 months) from the date of certificate issuance or beyond the time period approved by the commissioner at the date of certificate issuance, whichever is greater. See 12 VAC 5-220-440 and 12 VAC 5-220-450.

"Standard review process" means the process utilized in the review of all certificate of public need requests with the exception of:

1. ~~Certain bed relocation, equipment replacement, and new service introduction projects~~ relocations as specified in 12 VAC 5-220-280;
2. Certain projects which involve an increase in the number of beds in which nursing facility or extended care services are provided as specified in 12 VAC 5-220-325.

"State Medical Facilities Plan" means the planning document adopted by the Board of Health which shall include, but not be limited to (i) methodologies for projecting need for medical care facility beds and services; (ii) statistical information on the availability of medical care facilities and services; and (iii) procedures, criteria and standards for review of applications for projects for medical care facilities and services. The most recent applicable State Medical Facilities Plan shall remain in force until any such chapter is amended, modified or repealed by the Board of Health.

~~*"Virginia Health Planning Board"* means the statewide health planning body established pursuant to § 32.1-122.02 of the Code of Virginia which serves as the analytical and technical resource to the Secretary of Health and Human Resources in matters requiring health analysis and planning.~~

12 VAC 5-220-90. Annual report.

~~The department shall prepare and shall distribute upon request an annual report on all certificate of public need applications considered by the State Health Commissioner. Such report shall include a general statement of the findings made in the course of each review, the status of applications for which there is a pending determination, an analysis of the consistency of the decisions with the recommendation made by the regional health planning agency and an analysis of the costs of authorized projects.~~

The commissioner shall annually report to the Governor and the General Assembly on the status of Virginia's certificate of public need program. The report shall be issued by October 1 of each year and shall include, but need not be limited to:

1. A summary of the commissioner's actions during the previous fiscal year pursuant to Virginia's certificate of public need law;

2. A five-year schedule for analysis of all project categories, which provides for the analysis of at least three project categories per year;

3. An analysis of the appropriateness of continuing the certificate of public need program for at least three project categories in accordance with the five-year schedule for analysis of all project categories;

4. An analysis of the effectiveness of the application review procedures used by the regional health planning agencies and the department required by § 32.1-102.6, which details the review time required during the past year for various project categories, the number of contested or opposed applications and the project categories of these contested or opposed projects, the number of applications upon which the regional health planning agencies have failed to act in accordance with the timelines of § 32.1-102.6 B, and the number of deemed approvals from the department because of their failure to comply with the timelines required by § 32.1-102.6 E, and any other data determined by the commissioner to be relevant to the efficient operation of the program;

5. An analysis of health care market reform in the Commonwealth and the extent, if any, to which such reform obviates the need for the certificate of public need program;

6. An analysis of the accessibility by the indigent to care provided by medical care facilities regulated pursuant to Virginia's certificate of public need law;

7. An analysis of the relevance of Virginia's certificate of public need law to the quality of care provided by medical care facilities regulated pursuant to this law; and

8. An analysis of equipment registrations required pursuant to § 32.1-102.1:1, including type of equipment, whether an addition or replacement, and the equipment costs.

12 VAC 5-220-105. Requirements for registration of the replacement of existing medical equipment which has been previously authorized as replacement equipment.

~~At least~~ Within 30 days before of any person contracts contracting to make, or is otherwise legally obligated obligating to make, a capital expenditure for the replacement of medical equipment or otherwise acquiring replacement medical equipment for the provision of services listed in subdivision 7 of the definition of "project" in 12 VAC 5-220-10, which has been previously authorized for replacement through the issuance of a certificate of public need, the person shall ~~notify~~ register in writing such equipment replacement with the commissioner and the appropriate regional health planning agency. Such registration shall be made on forms provided by the department. The ~~notification~~ registration shall identify the specific unit of equipment to be replaced and the estimated capital cost of the replacement and shall include documentation that the equipment to be replaced has previously been authorized as replacement equipment through issuance of a certificate of public need, registered

pursuant to former § 32.1-102.3:4 of the Code of Virginia or exempted pursuant to § 32.1-102.11 of the Code of Virginia.

12 VAC 5-220-150. Requirements for emergency replacement of equipment; notification of decision. (Repealed.)

~~The commissioner shall consider requests for emergency replacement of medical equipment as identified in Part I (12 VAC 5-220-10 et seq.) of this chapter. Such an emergency replacement is not a "project" of a medical care facility requiring a certificate of public need. To request authorization for such replacement, the owner of such equipment shall submit information to the commissioner to demonstrate that (i) the equipment is inoperable as a result of a mechanical failure, Act of God, or other reason which may not be attributed to the owner and the repair of such equipment is not practical or feasible; or (ii) the immediate replacement of the medical equipment is necessary to maintain an essential clinical health service or to assure the safety of patients or staff.~~

~~In determining that an application for emergency replacement of medical equipment is not a "project," the commissioner may condition an application on the provision of a level of care at a reduced rate to indigents or acceptance of patients receiving specialized care.~~

~~For purposes of this section, "inoperable" means that the equipment cannot be put into use, operation, or practice to perform the diagnostic or therapeutic clinical health service for which it was intended.~~

~~Within 15 days of the receipt of such requests the commissioner will notify the owner in the form of a letter of the decision to deny or authorize the emergency replacement of equipment.~~

12 VAC 5-220-160. Required considerations.

In determining whether a public need exists for a proposed project, the following factors shall be taken into account when applicable:

1. The recommendation and the reasons therefor of the appropriate regional health planning agency.

2. The relationship of the project to the applicable health plans of the regional health planning agency, ~~and the Virginia Health Planning Board and the Board of Health.~~

3. The relationship of the project to the long-range development plan, if any, of the person applying for a certificate.

4. The need that the population served or to be served by the project has for the project, *including, but not limited to, the needs of rural populations in areas having distinct and unique geographic, socioeconomic, cultural, transportation, and other barriers to access to care.*

5. The extent to which the project will be accessible to all residents of the area proposed to be served.

6. The area, population, topography, highway facilities and availability of the services to be provided by the project in the particular part of the health planning region in which the

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project is proposed, *in particular, the distinct and unique geographic, socioeconomic, cultural, transportation, and other barriers to access to care.*

7. Less costly or more effective alternate methods of reasonably meeting identified health service needs.

8. The immediate and long-term financial feasibility of the project.

9. The relationship of the project to the existing health care system of the area in which the project is proposed; *however, for projects proposed in rural areas, the relationship of the project to the existing health care services in the specific rural locality shall be considered.*

10. The availability of resources for the project.

11. The organizational relationship of the project to necessary ancillary and support services.

12. The relationship of the project to the clinical needs of health professional training programs in the area in which the project is proposed.

13. The special needs and circumstances of an applicant for a certificate, such as a medical school, hospital, multidisciplinary clinic, specialty center or regional health service provider, if a substantial portion of the applicant's services or resources or both is provided to individuals not residing in the health planning region in which the project is to be located.

14. The need and the availability in the health planning region for osteopathic and allopathic services and facilities and the impact on existing and proposed institutional training programs for doctors of osteopathy and medicine at the student, internship, and residency training levels.

15. The special needs and circumstances of health maintenance organizations. When considering the special needs and circumstances of health maintenance organizations, the commissioner may grant a certificate for a project if the commissioner finds that the project is needed by the enrolled or reasonably anticipated new members of the health maintenance organizations or the beds or services to be provided are not available from providers which are not health maintenance organizations or from other health maintenance organizations in a reasonable and cost effective manner.

16. The special needs and circumstances for biomedical and behavioral research projects which are designed to meet a national need and for which local conditions offer special advantages.

17. The costs and benefits of the construction associated with the proposed project.

18. The probable impact of the project on the costs of and charges for providing health services by the applicant for a certificate and on the costs and charges to the public for providing health services by other persons in the area.

19. Improvements or innovations in the financing and delivery of health services which foster competition and serve to promote quality assurance and cost effectiveness.

20. In the case of health services or facilities proposed to be provided, the efficiency and appropriateness of the use of existing services and facilities in the area similar to those proposed, *including, in the case of rural localities, any distinct and unique geographic, socioeconomic, cultural, transportation, and other barriers to access to care.*

12 VAC 5-220-180. Application forms.

A. Letter of intent. An applicant shall file a letter of intent with the commissioner to request appropriate application forms, and submit a copy of that letter to the appropriate regional health planning agency, by the later of (i) 30 days prior to the submission of an application for a project included within a particular batch group or (ii) 10 days after the first letter of intent is filed for a project within a particular batch group for the same or similar services and facilities which are proposed for the same planning district or medical service area. The letter shall identify the owner, the type of project for which an application is requested, and the proposed scope (size) and location of the proposed project. The department shall transmit application forms to the applicant within seven days of the receipt of the letter of intent. A letter of intent filed with the department shall be considered void one year after the date of receipt of such letter. (See 12 VAC 5-220-310 C.)

B. Application fees. The department shall collect application fees for applications that request a certificate of public need. The fee required for an application shall be ~~computed as follows:~~ *1.0% of the proposed expenditure for the project, but not less than \$1,000 and no more than \$20,000.*

~~1. For projects with a capital expenditure of \$0 up to and including \$1,000,000, the application fee is the greater of 1.0% of the total capital expenditure or \$1,000;~~

~~2. For projects with a capital expenditure of \$1,000,001 up to and including \$2,000,000, the application fee is \$10,000 plus .25% of the capital expenditure above \$1,000,000;~~

~~3. For projects with a capital expenditure of \$2,000,001 up to and including \$3,000,000, the application fee is \$12,500 plus .25% of the capital expenditure above \$2,000,000;~~

~~4. For projects with a capital expenditure of \$3,000,001 up to and including \$4,000,000, the application fee is \$15,000 plus .25% of the capital expenditure above \$3,000,000;~~

~~5. For projects with a capital expenditure of \$4,000,001 up to and including \$5,000,000, the application fee is \$17,500 plus .25% of the capital expenditure above \$4,000,000; and~~

~~6. For projects with a capital expenditure of \$5,000,001 or more, the application fee is \$20,000.~~

No application will be deemed to be complete for review until the required application fee is paid. (See 12 VAC 5-220-310 C.)

C. Filing application forms. Applications must be submitted at least 40 days prior to the first day of a scheduled review cycle to be considered for review in the same cycle. All applications including the required data and information shall be prepared in triplicate; two copies to be submitted to the department; one copy to be submitted to the appropriate regional health planning agency. *In order to verify the date of the*

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department's and the appropriate regional health planning agency's receipt of the application, the applicant shall transmit the document by certified mail or a delivery service, return receipt requested, or shall deliver the document by hand, with a signed receipt to be provided. No application shall be deemed to have been submitted until required copies have been received by the department and the appropriate regional health planning agency. (See 12 VAC 5-220-200.)

12 VAC 5-220-200. One hundred ~~twenty-day~~ *ninety-day* review cycle.

The department shall review the following groups of completed applications in accordance with the following ~~120-day~~ *190-day* scheduled review cycles and the following descriptions of projects within each group, except as provided for in 12 VAC 5-220-220.

| BATCH GROUP | GENERAL DESCRIPTION | REVIEW CYCLE | |
|-------------|--|--------------------|---|
| | | Begins | Ends |
| A | General Hospitals/ Obstetrical Services/ Neonatal Special Care Services | Feb. 10 Aug. 10 | June 10 <i>Aug. 18</i> Dec. 8 <i>Feb. 16</i> |
| B | Open Heart Surgery/Cardiac Catheterization/ Catheterization/ Ambulatory Surgery Centers/ Operating Room Additions/ Transplant Services | Mar. 10 Sep. 10 | Jul. 8 <i>Sep. 16</i> Jan. 8 <i>Mar. 19</i> |
| C | Psychiatric Facilities/ Substance Abuse Treatment/ Mental Retardation Facilities | Apr. 10 Oct. 10 | Aug. 8 <i>Oct. 17</i> Feb. 7 <i>Apr. 18</i> |
| D | Diagnostic Imaging Facilities/ Services | May 10 Nov. 10 | Sep. 7 <i>Nov. 16</i> Mar. 10 <i>May 19</i> |
| E | Medical Rehabilitation Beds/Services | June 10 Dec. 10 | Oct. 8 <i>Dec. 17</i> Apr. 9 <i>Jun. 18</i> |
| F | Selected Therapeutic Facilities/ Services | July 10 Jan. 10 | Nov. 7 <i>Jan. 16</i> May 10 <i>Jul. 18</i> |

| | | | |
|---|--|---|--|
| G | Nursing Home Beds at Retirement Communities/ | Jan. 10 Mar. 10 May 10 July 10 | May 10 <i>Jul. 18</i> Jul. 8 <i>Sep. 16</i> Sep. 7 <i>Nov. 16</i> Nov. 7 <i>Jan. 16</i> |
| | Bed Relocations/ | Sep. 10 | Jan. 8 <i>Mar. 19</i> |
| | Miscellaneous Expenditures by Nursing Homes | Nov. 10 | Mar. 10 <i>May 19</i> |

Batch Group A includes:

1. The establishment of a general hospital.
2. An increase in the total number of general acute care beds in an existing or authorized general hospital.
3. The relocation at the same site of 10 general hospital beds or 10% of the general hospital beds of a medical care facility, whichever is less, from one existing physical facility to any other in any two-year period *if such relocation involves a capital expenditure of \$5 million or more. (See 12 VAC 5-220-280.)*
4. The introduction into an existing medical care facility of any new neonatal special care or obstetrical services which the facility has not provided in the previous 12 months.
5. Any capital expenditure of \$5 million or more, not defined as a project category included in Batch Groups B through G, by or in behalf of a general hospital.

Batch Group B includes:

1. The establishment of a specialized center, clinic, or portion of a physician's office developed for the provision of outpatient or ambulatory surgery or cardiac catheterization services.
2. An increase in the total number of operating rooms in an existing medical care facility or establishment of operating rooms in a new facility.
3. The introduction into an existing medical care facility of any new cardiac catheterization, open heart surgery, or organ or tissue transplant services which the facility has not provided in the previous 12 months.
4. The addition ~~or replacement~~ by an existing medical care facility of any medical equipment for the provision of cardiac catheterization services ~~unless a certificate of public need authorizing replacement of equipment was previously issued for the specific unit of equipment to be replaced.~~
5. Any capital expenditure of \$5 million or more, not defined as a project category in Batch Group A or Batch Groups C through G, by or in behalf of a specialized center, clinic, or portion of a physician's office developed for the provision of outpatient or ambulatory surgery or cardiac catheterization services.
6. Any capital expenditure of \$5 million or more, not defined as a project category in Batch Group A or Batch Groups C through G, by or in behalf of a medical care facility, which is primarily related to the provision of surgery, cardiac catheterization, open heart surgery, or organ or tissue transplant services.

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Batch Group C includes:

1. The establishment of a mental hospital, psychiatric hospital, intermediate care facility established primarily for the medical, psychiatric or psychological treatment and rehabilitation of alcoholics or drug addicts, or mental retardation facility.
2. An increase in the total number of beds in an existing or authorized mental hospital, psychiatric hospital, intermediate care facility established primarily for the medical, psychiatric or psychological treatment and rehabilitation of alcoholics or drug addicts, or mental retardation facility.
3. An increase in the total number of mental hospital, psychiatric hospital, substance abuse treatment and rehabilitation, or mental retardation beds in an existing or authorized medical care facility which is not a dedicated mental hospital, psychiatric hospital, intermediate care facility established primarily for the medical, psychiatric or psychological treatment and rehabilitation of alcoholics or drug addicts, or mental retardation facility.
4. The relocation at the same site of 10 mental hospital, psychiatric hospital, substance abuse treatment and rehabilitation, or mental retardation beds or 10% of the mental hospital, psychiatric hospital, substance abuse treatment and rehabilitation, or mental retardation beds of a medical care facility, whichever is less, from one existing physical facility to another in any two-year period *if such relocation involves a capital expenditure of \$5 million or more.* (See 12 VAC 5-220-280.)
5. The introduction into an existing medical care facility of any new psychiatric or substance abuse treatment service which the facility has not provided in the previous 12 months.
6. Any capital expenditure of \$5 million or more, not defined as a project category in Batch Groups A and B or Batch Groups D through G, by or in behalf of a mental hospital, psychiatric hospital, intermediate care facility established primarily for the medical, psychiatric or psychological treatment and rehabilitation of alcoholics or drug addicts, or mental retardation facility.
7. Any capital expenditure of \$5 million or more, not defined as a project category in Batch Groups A and B or Batch Groups D through G, by or in behalf of a medical care facility, which is primarily related to the provision of mental health, psychiatric, substance abuse treatment or rehabilitation, or mental retardation services.

Batch Group D includes:

1. The establishment of a specialized center, clinic, or that portion of a physician's office developed for the provision of computed tomographic (CT) scanning, magnetic resonance imaging (MRI), magnetic source imaging (MSI), positron emission tomographic (PET) scanning, or nuclear medicine imaging, *except for the purpose of nuclear cardiac imaging.*
2. The introduction into an existing medical care facility of any new computed tomography (CT), magnetic resonance imaging (MRI), magnetic source imaging (MSI), positron

emission tomographic (PET) scanning, or nuclear medicine imaging services ~~which, except for the purpose of nuclear cardiac imaging that the facility has not provided in the previous 12 months.~~

3. The addition ~~or replacement~~ by an existing medical care facility of any equipment for the provision of computed tomography (CT), magnetic resonance imaging (MRI), magnetic source imaging (MSI), or positron emission tomographic (PET) scanning ~~unless a certificate of public need authorizing replacement of equipment was previously issued for the specific unit of equipment to be replaced.~~

4. Any capital expenditure of \$5 million or more, not defined as a project category in Batch Groups A through C or Batch Groups E through G, by or in behalf of a specialized center, clinic, or that portion of a physician's office developed for the provision of computed tomographic (CT) scanning, magnetic resonance imaging (MRI), magnetic source imaging (MSI), positron emission tomographic (PET) scanning, or nuclear medicine imaging, *except that portion of a physician's office dedicated to providing nuclear cardiac imaging.*

5. Any capital expenditure of \$5 million or more, not defined as a project category in Batch Groups A through C or Batch Groups E through G, by or in behalf of a medical care facility, which is primarily related to the provision of computed tomographic (CT) scanning, magnetic resonance imaging (MRI), magnetic source imaging (MSI), positron emission tomographic (PET) scanning, or nuclear medicine imaging, *except for the purpose of nuclear cardiac imaging.*

Batch Group E includes:

1. The establishment of a medical rehabilitation hospital.
2. An increase in the total number of beds in an existing or authorized medical rehabilitation hospital.
3. An increase in the total number of medical rehabilitation beds in an existing or authorized medical care facility which is not a dedicated medical rehabilitation hospital.
4. The relocation at the same site of 10 medical rehabilitation beds or 10% of the medical rehabilitation beds of a medical care facility, whichever is less, from one existing physical facility to another in any two-year period, *if such relocation involves a capital expenditure of \$5 million or more.* (See 12 VAC 220-280.)
5. The introduction into an existing medical care facility of any new medical rehabilitation service which the facility has not provided in the previous 12 months.
6. Any capital expenditure of \$5 million or more, not defined as a project category in Batch Groups A through D or Batch Groups F and G, by or in behalf of a medical rehabilitation hospital.
7. Any capital expenditure of \$5 million or more, not defined as a project category in Batch Groups A through D or Batch Groups F and G, by or in behalf of a medical care facility, which is primarily related to the provision of medical rehabilitation services.

Batch Group F includes:

1. The establishment of a specialized center, clinic, or that portion of a physician's office developed for the provision of gamma knife surgery, lithotripsy, or radiation therapy.

2. Introduction into an existing medical care facility of any new gamma knife surgery, lithotripsy, or radiation therapy services which the facility has never provided or has not provided in the previous 12 months.

3. The addition or replacement by an existing medical care facility of any medical equipment for the provision of gamma knife surgery, lithotripsy, or radiation therapy ~~unless a certificate of public need authorizing replacement of equipment was previously issued for the specific unit of equipment to be replaced.~~

4. Any capital expenditure of \$5 million or more, not defined as a project in Batch Groups A through E or Batch Group G, by or in behalf of a specialized center, clinic, or that portion of a physician's office developed for the provision of gamma knife surgery, lithotripsy, or radiation therapy.

5. Any capital expenditure of \$5 million or more, not defined as a project in Batch Groups A through E or Batch Group G, by or in behalf of a medical care facility, which is primarily related to the provision of gamma knife surgery, lithotripsy, or radiation therapy.

Batch Group G includes:

1. The establishment of a nursing home, intermediate care facility, or extended care facility of a continuing care retirement community by a continuing care provider registered with the State Corporation Commission pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2 of the Code of Virginia.

2. The establishment of a nursing home, intermediate care facility, or extended care facility that does not involve an increase in the number of nursing home facility beds ~~in Virginia~~ within a planning district.

3. An increase in the total number of beds in an existing or authorized nursing home, intermediate care facility, or extended care facility of a continuing care retirement community by a continuing care provider registered with the State Corporation Commission pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2 of the Code of Virginia.

4. An increase in the total number of beds in an existing or authorized nursing home, intermediate care facility, or extended care facility that does not involve an increase in the number of nursing home facility beds ~~in Virginia~~ within a planning district.

5. The relocation at the same site of 10 nursing home, intermediate care facility, or extended care facility beds or 10% of the nursing home, intermediate care facility, or extended care facility beds of a medical care facility, whichever is less, from one physical facility to another in any two-year period, *if such relocation involves a capital expenditure of \$5 million or more.* (See 12 VAC 5-220-280.)

6. Any capital expenditure of \$5 million or more, not defined as a project category in Batch Groups A through F, by or in behalf of a nursing home, intermediate care facility, or

extended care facility, which does not increase the total number of beds of the facility.

7. Any capital expenditure of \$5 million or more, not defined as a project category in Batch Groups A through F, by or in behalf of a medical care facility, which is primarily related to the provision of nursing home, intermediate care, or extended care services, and does not increase the number of beds of the facility.

12 VAC 5-220-230. Review of complete application.

A. Review cycle. At the close of the work day on the ~~40th~~ *tenth* day of the month, the department shall provide written notification to applicants specifying the acceptance date and review schedule of completed applications, including a ~~proposed~~ *the* date for any informal fact-finding conference that may be held ~~between the eightieth and ninetieth day of the review cycle.~~ The regional health planning agency shall conduct no more than two meetings, one of which must be a public hearing conducted by the regional health planning agency board or a subcommittee of the board and provide applicants with an opportunity, prior to the vote, to respond to any comments made about the project by the regional health planning agency staff, any information in a staff report, or comments by those voting in completing its review and recommendation by the ~~60th~~ *sixtieth* day of the cycle. By the ~~70th~~ *seventieth* day of the review cycle, the department shall complete its review and recommendation of an application and transmit the same to the applicants and other appropriate persons. ~~Such notification shall also include the proposed date, time and place of any informal fact-finding conference. By the seventy-fifth day of the review cycle, the department shall transmit to the applicant and the appropriate other persons its determination whether an informal fact-finding conference is necessary.~~

An informal fact-finding conference shall be held when (i) determined necessary by the department or (ii) requested by any person ~~showing~~ *seeking to demonstrate* good cause. Any person seeking to demonstrate good cause shall file, no later than ~~40~~ *four* days after the department has completed its review and recommendation of an application and has transmitted the same to the applicants and to persons who have prior to the issuance of the report requested a copy in writing, written notification with the commissioner, applicants and other competing applicants, and regional health planning agency stating the grounds for good cause and providing the factual basis therefor under oath.

For purposes of this section, "good cause" means that (i) there is significant, relevant information not previously presented at and not available at the time of the public hearing, (ii) there have been significant changes in factors or circumstances relating to the application subsequent to the public hearing, or (iii) there is a substantial material mistake of fact or law in the department staff's report on the application or in the report submitted by the regional health planning agency. See ~~§ 9-6.14:14~~ *2.2-4019* of the Code of Virginia. ~~The commissioner shall within five days of receipt review any filing that claims good cause and determine whether the facts presented in writing demonstrate a likelihood that good cause will be shown. If there is such a likelihood, an informal fact-finding conference shall be held on the project and on the~~

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~~issue of whether good cause was shown. If such a likelihood is not demonstrated, the person asserting good cause may seek further to demonstrate good cause at any informal fact-finding conference otherwise scheduled on the project. If no conference has otherwise been scheduled, an informal conference shall be scheduled promptly to ascertain whether facts exist that demonstrate good cause. Within five days of any such conference, the commissioner shall issue his final decision on whether good cause has been shown. No informal fact-finding conference shall be required on any project solely upon the request of a person claiming good cause unless the commissioner finds that good cause has been shown. Where good cause is not found by the commissioner to have been shown, the person claiming it may not participate as a party to the case in any administrative proceeding.~~

~~The commissioner shall render a final determination by the 120th day of the review cycle. Unless agreed to by the applicant and, when applicable, the parties to any informal fact-finding conference held, the review schedule shall not be extended.~~

B. Time period for review. The review period shall begin on the first day of the applicable review cycle within which an application is determined to be complete, in accordance with scheduled batch review cycles described in 12 VAC 5-220-200. If the application is not determined to be complete for the applicable batch cycle within 40 calendar days from the date of submission, the application may be refiled in the next applicable batch cycle.

If the regional health planning agency has not completed its review by the sixtieth day of the review cycle, or such other period in accordance with the applicant's request for extension, and submitted its recommendation within 10 calendar days after the completion of its review, the department shall, on the eleventh day after expiration of the regional health planning agency's review period, proceed as if the regional health planning agency has recommended approval of the proposed project.

In any case in which an informal fact-finding conference is not held, the project record shall be closed on the earlier of (i) the date established for holding the informal fact-finding conference or (ii) the date that the department determines that an informal fact-finding conference is not necessary. (See 12 VAC 5-220-230 A.)

In any case in which an informal fact-finding conference is held, a date shall be established for closing of the record that shall not be more than 45 calendar days after the date for holding the informal fact-finding conference. Any informal fact-finding conference shall be to consider the information and issues in the record and shall not be a de novo review.

C. Determination by the commissioner. If a determination whether a public need exists for a project is not made by the commissioner within 15 calendar days of the closing of the record, the commissioner shall notify the attorney general, in writing, that the application shall be deemed approved unless the determination shall be made within 40 calendar days of the closing of the record. The commissioner shall transmit copies of such notice to the attorney general and to other

parties to the case and any person petitioning for good cause standing.

In any case when a determination whether a public need exists for a project is not made by the commissioner within 40 calendar days after closing of the record, the department shall immediately refund 50% of the application fee paid in accordance with 12 VAC 5-220-180 B, and the application shall be deemed approved and a certificate shall be granted.

If a determination whether a public need for a project exists is not made by the commissioner within 15 calendar days of the closing of the record, any person who has filed an application competing in the relevant batch review cycle or who has filed an application in response to the relevant Request for Applications issued pursuant to 12 VAC 5-220-355 may, prior to the application being deemed approved, institute a proceeding for mandamus against the commissioner in any circuit court of competent jurisdiction.

If the court issues a writ of mandamus against the commissioner, the department shall be liable for the costs of the action together with reasonable attorney's fee as determined by the court.

Upon the filing of a petition for a writ of mandamus, the relevant application shall not be deemed approved, regardless of the lapse of time between the closing of the record and the final decision.

Deemed approvals shall be construed as the commissioner's case decision on the application pursuant to the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia) and shall be subject to judicial review on appeal as the commissioner's case decision in accordance with such act.

Any person who has sought to participate in the department's review of such deemed-to-be-approved application as a person showing good cause who has not received a final determination from the commissioner concerning the good cause petition prior to the date on which the application was approved, shall be deemed to be a person showing good cause for purposes of appeal of a deemed-to-be-approved certificate.

The applicant, and only the applicant, shall have the authority to extend any of the time periods for review of the application, which are specified in 12 VAC 5-220-230.

For purposes of project review, any scheduled deadlines that fall on a weekend or state holiday shall be advanced to the next work day.

~~B.~~ *D. Regional health planning agency required notifications. Upon notification of the acceptance date of a complete application as set forth in subsection A of this section, the regional health planning agency shall provide written notification of its review schedule to the applicant. The regional health planning agency shall notify health care providers and specifically identifiable consumer groups who may be affected by the proposed project directly by mail and shall also give notice of the public hearing in a newspaper of general circulation in such county or city wherein a project is proposed or a contiguous county or city at least nine days prior to such public hearing. Such notification by the regional*

health planning agency shall include: (i) the date and location of the public hearing which shall be conducted on the application except as otherwise provided in this chapter, in the county or city wherein a project is proposed or a contiguous county or city and (ii) the date, time and place the final recommendation of the regional health planning agency shall be made. The regional health planning agency shall maintain a verbatim record which may be a tape recording of the public hearing. Such public hearing record shall be maintained for at least a one-year time period following the final decision on a certificate of public need application. See definition of "public hearing."

~~C.~~ *E.* Ex parte contact. After commencement of a public hearing and before a final decision is made, there shall be no ex parte contacts between the State Health Commissioner and any person acting on behalf of the applicant or holder of a certificate or any person opposed to the issuance or in favor of revocation of a certificate of public need, unless written notification has been provided. See definition of "ex parte."

12 VAC 5-220-270. Action on an application.

A. Commissioner's responsibility. Decisions as to approval or disapproval of applications or a portion thereof for certificates of public need shall be rendered by the commissioner. Any decision to issue or approve the issuance of a certificate shall be consistent with the most recent applicable provisions of the State Medical Facilities Plan. However, if the commissioner finds, upon presentation of appropriate evidence, that the provisions of either such plan are *not relevant to a rural locality's needs*, inaccurate, outdated, inadequate or otherwise inapplicable, the commissioner, consistent with such finding, may issue or approve the issuance of a certificate and shall initiate procedures to make appropriate amendments to such plan.

Conditions of approval. The commissioner may condition the approval of an application for a project (i) on the agreement by the applicant to provide an acceptable level of care at a reduced rate to indigents, or (ii) on the agreement of the applicant to provide care to persons with special needs, or (iii) upon the agreement of the applicant to facilitate the development and operation of primary medical care services in designated medically underserved areas of the applicant's service area. The terms of such agreements shall be specified in writing prior to the commissioner's decision to approve a project. Any person willfully refusing, failing or neglecting to honor such agreement shall be subject to a civil penalty of \$100 per violation per day from the date of receipt from the department of written notice of noncompliance until the date of compliance. Upon information and belief that a person has failed to honor such agreement in accordance with this provision, the department shall notify the person in writing and 15 days shall be provided for response in writing including a plan for immediate correction. In the absence of an adequate response or necessary compliance or both, a judicial action shall be initiated in accordance with the provisions of § 32.1-27 of the Code of Virginia.

B. Notification process-extension of review time. The commissioner shall make a final determination on an application for a certificate of public need and provide written notification detailing the reasons for such determination to the

applicant with a copy to the regional health planning agency ~~by the 120th day of the review cycle unless an extension is agreed to by the applicant and an informal fact-finding conference described in 12 VAC 5-220-230 is held. When an informal fact-finding conference is held, the 120-day review cycle shall not be extended unless agreed to by the parties to the conference within the time frames specified in 12 VAC 5-220-230 B unless authorization is given by the applicants to extend the time period.~~ Such written notification shall also reference the factors and bases considered in making a decision on the application and, if applicable, the remedies available for appeal of such decision and the progress reporting requirements. The commissioner may approve a portion of a project provided the portion to be approved is agreed to by the applicant following consultation, which may be subject to the ex parte provision of this chapter, between the commissioner and the applicant.

12 VAC 5-220-280. Applicability.

Projects of medical care facilities that ~~satisfy the criteria set forth below as determined by the State Health Commissioner shall be subject to an expedited review process:~~ involve relocation at the same site of 10 beds or 10% of the beds, whichever is less, from one existing physical facility to another, when the cost of such relocation is less than \$5 million, shall be subject to an expedited review process.

~~1. Relocation at the same site of 10 beds or 10% of the beds, whichever is less, from one existing physical facility to another when the cost of such relocation is less than \$5 million.~~

~~2. The replacement at the same site by an existing medical care facility of any medical equipment for the provision of cardiac catheterization, computed tomography (CT), lithotripsy, magnetic resonance imaging (MRI), open heart surgery, positron emission tomographic scanning (PET), or radiation therapy when the medical care facility meets applicable standards for replacement of such medical equipment which are set forth in the State Medical Facilities Plan.~~

12 VAC 5-220-355. Application forms.

A. Letter of intent. A nursing home bed applicant shall file a letter of intent with the commissioner to request appropriate application forms, and submit a copy of that letter to the appropriate regional health planning agency by the letter of intent deadline specified in the RFA. The letter shall identify the owner, the type of project for which an application is requested, and the proposed scope (size) and location of the proposed project. The department shall transmit application forms to the applicant within seven days of the receipt of the letter of intent. A letter of intent filed with the department shall be considered void if an application is not filed for the project by the application deadline specified in the RFA.

B. Application fees. The department shall collect application fees for applications that request a nursing home bed certificate of public need. The fee required for an application is ~~the lesser of 1.0% of the proposed capital expenditure for the project or \$10,000~~ but no less than \$1,000 and no more than \$20,000. No application will be deemed to be complete for review until the required application fee is paid.

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C. Filing application forms. Applications must be submitted to the department and the appropriate regional health planning agency by the application filing deadline specified in the RFA. All applications including the required data and information shall be prepared in triplicate; two copies to be submitted to the department; and one copy to be submitted to the appropriate regional health planning agency. *In order to verify the department and the appropriate regional health planning agency's receipt of the application, the applicant shall transmit the document by certified mail or a delivery service, return receipt requested, or shall deliver the document by hand, with the signed receipt to be provided.* No application shall be deemed to have been submitted until required copies have been received by the department and the appropriate regional health planning agency.

12 VAC 5-220-385. Review of complete application.

A. Review cycle. The department shall provide written notification to applicants specifying the acceptance date and review schedule of completed applications, including ~~a proposed~~ the date for any informal fact-finding conference that may be held ~~between the eightieth and ninetieth day of the review cycle.~~ The regional health planning agency shall conduct no more than two meetings, one of which must be a public hearing conducted by the regional health planning agency board or a subcommittee of the board and provide applicants with an opportunity, prior to the vote, to respond to any comments made about the project by the regional health planning agency staff, any information in a staff report, or comments by those voting in completing its review and recommendation by the ~~60th~~ *sixtieth* day of the cycle. By the ~~70th~~ *seventieth* day of the review cycle, the department shall complete its review and recommendation of an application and transmit the same to the applicant or applicants and other appropriate persons. ~~Such notification shall also include the proposed date, time and place of any informal fact-finding conference.~~ By the *seventy-fifth* day of the review cycle, the department shall transmit to the applicants and other appropriate persons, its determination whether an informal fact-finding conference is necessary.

An informal fact-finding conference shall be held when (i) determined necessary by the department or (ii) requested by any person ~~showing~~ *seeking to demonstrate* good cause. Any person seeking to demonstrate good cause shall file, no later than ~~40~~ *four* days after the department has completed its review and recommendation of an application and has transmitted the same to the applicants and to persons who have prior to the issuance of the report requested a copy in writing, written notification with the commissioner, applicant or applicants and other competing applicants, and regional health planning agency stating the grounds for good cause and providing the factual basis therefor under oath.

For purposes of this section, "good cause" means that (i) there is significant, relevant information not previously presented at and not available at the time of the public hearing, (ii) there have been significant changes in factors or circumstances relating to the application subsequent to the public hearing, or (iii) there is a substantial material mistake of fact or law in the department staff's report on the application or in the report submitted by the regional health planning agency. (See

~~§ 9-6.14:14 32.1-102.6 of the Code of Virginia.) The commissioner shall within five days of receipt review any filing that claims good cause and determine whether the facts presented in writing demonstrate a likelihood that good cause will be shown. If there is such a likelihood, an informal fact-finding conference shall be held on the project and on the issue of whether good cause was shown. If such a likelihood is not demonstrated, the person asserting good cause may seek further to demonstrate good cause at any informal fact-finding conference otherwise scheduled on the project. If no conference has otherwise been scheduled, an informal conference shall be scheduled promptly to ascertain whether facts exist that demonstrate good cause. Within five days of any such conference, the commissioner shall issue his final decision on whether good cause has been shown. No informal fact-finding conference shall be required on any project solely upon the request of a person claiming good cause unless the commissioner finds that good cause has been shown. Where good cause is not found by the commissioner to have been shown, the person claiming it may not participate as a party to the case in any administrative proceeding.~~

~~The commissioner shall render a final determination by the 120th day of the review cycle. Unless agreed to by the applicant or applicants and, when applicable, the parties to any informal fact-finding conference held, the review schedule shall not be extended.~~

B. Time period for review. The review period shall begin on the first day of the applicable review cycle within which an application is determined to be complete, in accordance with scheduled batch review cycles described in 12 VAC 5-220-200. If the application is not determined to be complete for the applicable batch cycle within 40 calendar days from the date of submission, the application may be refiled in the next applicable batch cycle.

If the regional health planning agency has not completed its review by the sixtieth day of the review cycle, or such other period in accordance with the applicant's request for extension, and submitted its recommendation within ten calendar days after the completion of its review, the department shall, on the eleventh day after expiration of the regional health planning agency's review period, proceed as if the regional health planning agency has recommended approval of the proposed project.

In any case in which an informal fact-finding conference is not held, the project record shall be closed on the earlier of (i) the date established for holding the informal fact-finding conference or (ii) the date that the department determines that an informal fact-finding conference is not necessary. (See 12 VAC 5 220-230 A.)

In any case in which an informal fact-finding conference is held, a date shall be established for closing of the record which shall not be more than 30 calendar days after the date for holding the informal fact-finding conference.

C. Determination by the commissioner. If a determination whether a public need exists for a project is not made by the commissioner within 45 calendar days of the closing of the record, the commissioner shall notify the applicant or applicants and any person seeking to show good cause, in

writing, that the application or the applications of each shall be deemed approved 25 calendar days after the expiration of such 45-calendar-day period, unless the receipt of recommendations from the person performing the hearing officer functions permits the commissioner to issue his case decision within that 25-calendar-day period. The validity or timeliness of the aforementioned notice shall not, in any event, prevent, delay or otherwise impact the effectiveness of this section.

In any case when a determination whether a public need exists for a project is not made by the commissioner within 70 calendar days after closing of the record, the application shall be deemed approved and a certificate shall be granted.

If a determination whether a public need for a project exists is not made by the commissioner within 45 calendar days of the closing of the record, any application who is competing in the relevant batch review cycle or who has filed an application in response to the relevant Request for Applications issued pursuant to 12 VAC 5-220-355 may, prior to the application being deemed approved petition for immediate injunctive relief pursuant to § 2.2-4030 of the Code of Virginia, naming as respondents the commissioner and all parties to the case. During the pendency of proceeding, no applications shall be deemed to be approved. In such a proceeding, the provisions of § 2.2-4030 of the Code of Virginia shall apply.

Deemed approvals shall be construed as the commissioner's case decision on the application pursuant to the Administrative Process Act (§ 2.2-4000 et seq.) and shall be subject to judicial review on appeal as the commissioner's case decision in accordance with such act.

Any person who has sought to participate in the department's review of such deemed-to-be-approved application as a person showing good cause who has not received a final determination from the commissioner concerning such attempt to show good cause petition prior to the date on which the application was approved, shall be deemed to be a person showing good cause for purposes of appeal of a deemed-to-be-approved certificate.

In any appeal of the commissioner's case decision granting a certificate of public need pursuant to a Request for Applications issued pursuant to § 32.1-102.3:2 of the Code of Virginia, the court may require the appellant to file a bond pursuant to § 8.01-676.1 of the Code of Virginia, in such sum as shall be fixed by the court for protection of all parties interested in the case decision, conditioned on the payment of all damages and costs incurred in consequence of such appeal.

The applicants, and only the applicants, shall have the authority to extend any of the time periods for review of the application, which are specified in 12 VAC 5-220-230. If all applicants consent to extending any time period in this section, the commissioner, with the concurrence of the applicants, shall establish a new schedule for the remaining time periods.

B. D. Regional health planning agency required notifications. Upon notification of the acceptance date of a complete application as set forth in subsection A of this section, the regional health planning agency shall provide written

notification of its review schedule to the applicant. The regional health planning agency shall notify health care providers and specifically identifiable consumer groups who may be affected by the proposed project directly by mail and shall also give notice of the public hearing in a newspaper of general circulation in such county or city wherein a project is proposed or a contiguous county or city at least nine days prior to such public hearing. Such notification by the regional health planning agency shall include: (i) the date and location of the public hearing which shall be conducted on the application except as otherwise provided in this chapter, in the county or city wherein a project is proposed or a contiguous county or city; and (ii) the date, time and place the final recommendation of the regional health planning agency shall be made. The regional health planning agency shall maintain a verbatim record which may be a tape recording of the public hearing. Such public hearing record shall be maintained for at least a one-year time period following the final decision on a certificate of public need application. See definition of "public hearing."

C. E. Ex parte contact. After commencement of a public hearing and before a final decision is made, there shall be no ex parte contacts between the State Health Commissioner and any person acting on behalf of the applicant or holder of a certificate or any person opposed to the issuance or in favor of revocation of a certificate of public need, unless written notification has been provided. See definition of "ex parte."

12 VAC 5-220-420. Action on an application.

A. Commission's responsibility. Decisions as to approval or disapproval of applications or a portion thereof for certificates of public need shall be rendered by the commissioner. Any decision to issue or approve the issuance of a certificate shall be consistent with the most recent applicable provisions of the State Medical Facilities Plan. However, if the commissioner finds, upon presentation of appropriate evidence, that the provisions of such plan are *not relevant to a rural locality's needs*, inaccurate, outdated, inadequate or otherwise inapplicable, the commissioner, consistent with such finding, may issue or approve the issuance of a certificate and shall initiate procedures to make appropriate amendments to such plan.

The commissioner may condition the approval of an application for a project (i) on the agreement by the applicant to provide an acceptable level of care at a reduced rate to indigents or, (ii) on the agreement of the applicant to provide care to persons with special needs, or (iii) upon the agreement of the applicant to facilitate the development and operation of primary medical care services in designated medically underserved areas of the applicant's service area. The terms of such agreements shall be specified in writing prior to the commissioner's decision to approve a project. Any person willfully refusing, failing or neglecting to honor such agreements shall be subject to a civil penalty of \$100 per violation per day from the date of receipt from the department of written notice of noncompliance until the date of compliance. Upon information and belief that a person has failed to honor such agreement in accordance with this provision, the department shall notify the person in writing and 15 days shall be provided for a response in writing including a

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plan for immediate correction. In the absence of an adequate response or necessary compliance or both, a judicial action shall be initiated in accordance with the provisions of § 32.1-27 of the Code of Virginia.

~~B. Notification process - extension of review time. The commissioner shall make a final determination on an application for a certificate of public need and provide written notification detailing the reasons for such determination to the applicant with a copy to the regional health planning agency by the 120th day of the review cycle unless an extension is agreed to by the applicant and an informal fact-finding conference described in 12 VAC 5-220-380 is held. When an informal fact-finding conference is held, the 120-day review cycle shall not be extended unless agreed to by the parties to the conference within the time frames specified in 12 VAC 5-220-385 B unless an authorization is given by the applicants to extend the time period.~~ Such written notification shall also reference the factors and bases considered in making a decision on the application and, if applicable, the remedies available for appeal of such decision and the progress reporting requirements. The commissioner may approve a portion of a project provided the portion to be approved is agreed to by the applicant following consultation, which may be subject to the ex parte provision of this chapter, between the commissioner and the applicant.

12 VAC 5-220-470. Court review.

~~A. Appeal to circuit court. Appeals to a circuit court shall be governed by applicable provisions of Virginia's Administrative Process Act, § 9-6.14:15 2.2-4000 et seq. of the Code of Virginia.~~

~~Any applicant aggrieved by a final administrative decision on its application for a certificate, any third-party payor providing health care insurance or prepaid coverage to 5.0% or more of the patients in the applicant's service area, a regional health planning agency operating in the applicant's service area or, any person showing good cause or any person issued a certificate aggrieved by a final administrative decision to revoke said certificate, within 30 days after the decision, may obtain a review, as provided in § 9-6.14:17 of the Code of Virginia by the circuit court of the county or city where the project is intended to be or was constructed, located or undertaken. Notwithstanding the provisions of § 9-6.14:16 of the Administrative Process Act, no other person may obtain such review.~~

~~B. Designation of judge. The judge of the court referred to in subsection A of this section shall be designated by the Chief Justice of the Supreme Court from a circuit other than the circuit where the project is or will be under construction, located or undertaken.~~

~~C. Court review procedures. Within five days after the receipt of notice of appeal, the department shall transmit to the appropriate court all of the original papers pertaining to the matter to be reviewed. The matter shall thereupon be reviewed by the court as promptly as circumstances will reasonably permit. The court review shall be upon the record so transmitted. The court may request and receive such additional evidence as it deems necessary in order to make a proper disposition of the appeal. The court shall take due~~

~~account of the presumption of official regularity and the experience and specialized competence of the commissioner. The court may enter such orders pending the completion of the proceedings as are deemed necessary or proper. Upon conclusion of review, the court may affirm, vacate or modify the final administrative decision.~~

~~D. Further appeal. Any party to the proceeding may appeal the decision of the circuit court in the same manner as appeals are taken and as provided by law.~~

12 VAC 5-230-10. Definitions.

The following words and terms, when used in Chapters 230 (12 VAC 5-230-10 et seq.) through 360 (12 VAC 5-360-10 et seq.) shall have the following meanings, unless the context clearly indicated otherwise:

"Acceptability" means to the level of satisfaction expressed by consumers with the availability, accessibility, cost, quality, continuity and degree of courtesy and consideration afforded them by the health care system.

"Accessibility" means the ability of a population or segment of the population to obtain appropriate, available services. This ability is determined by economic, temporal, locational, architectural, cultural, psychological, organizational and informational factors which may be barriers or facilitators to obtaining services.

~~*"Acceptability" means to the level of satisfaction expressed by consumers with the availability, accessibility, cost, quality, continuity and degree of courtesy and consideration afforded them by the health care system.*~~

"Availability" means the quantity and types of health services that can be produced in a certain area, given the supply of resources to produce those services.

"Continuity of care" means the extent of effective coordination of services provided to individuals and the community over time, within and among health care settings.

"Cost" means all expenses incurred in the production and delivery of health services.

"Quality of care" means to the degree to which services provided are properly matched to the needs of the population, are technically correct, and achieve beneficial impact. Quality of care can include consideration of the appropriateness of physical resources, the process of producing and delivering services, and the outcomes of services on health status, the environment, and/or behavior.

"Rural" means territory, population, and housing units that are classified as "rural" by the Bureau of the Census of the United States Department of Commerce, Economic and Statistics Administration.

12 VAC 5-230-20. Preface.

Virginia's Certificate of Public Need law defines the State Medical Facilities Plan as the "planning document adopted by the Board of Health which shall include, but not be limited to, (i) methodologies for projecting need for medical facility beds and services; (ii) statistical information on the availability of medical facility beds and services; and (iii) procedures, criteria

and standards for the review of applications for projects for medical care facilities and services." (§ 32.1-102.1 of the Code of Virginia.)

Section 32.1-102.3 of the Code of Virginia states that, "Any decision to issue or approve the issuance of a certificate (of public need) shall be consistent with the most recent applicable provisions of ~~the State Health Plan and the State Medical Facilities Plan~~; provided, however, if the commissioner finds, upon presentation of appropriate evidence, ~~that the provisions of either such plan are not relevant to a rural locality's needs~~, inaccurate, outdated, inadequate or otherwise inapplicable, the commissioner, consistent with such finding, may issue or approve the issuance of a certificate and shall initiate procedures to make appropriate amendments to such plan."

Subsection B of § 32.1-102.3 of the Code of Virginia requires the commissioner to consider "the relationship" of a project "to the applicable health plans of the board" in "determining whether a public need for a project has been demonstrated."

This State Medical Facilities Plan is a comprehensive revision of the criteria and standards for COPN reviewable medical care facilities and services contained in the Virginia State Health Plan established from 1982 through 1987, and the Virginia State Medical Facilities Plan, last updated in July, 1988. This Plan supersedes the State Health Plan 1980 - 1984 and all subsequent amendments thereto save those governing facilities or services not presently addressed in this Plan.

12 VAC 5-240-10. Definitions.

The following words and terms, when used in this chapter shall have the following meanings, unless the context clearly indicates otherwise:

"Acute inpatient facility beds" means any beds included in the definitions of "general medical/surgical beds" and "intensive care beds."

"Acute care inpatient facility" means any hospital, ambulatory surgical center providing overnight accommodations, or other medical care facility which provides medical care and distinct housing of patients whose length of stay averages at most 30 days.

"Department" means the Virginia Department of Health.

"General medical/surgical beds" means acute care inpatient beds located in the following units or categories:

1. General medical/surgical units that are organized facilities and services (excluding those for newborns) available for the care and treatment of patients, not requiring specialized services; and
2. Pediatric units that are organized facilities and services maintained and operated as a distinct unit for regular use by inpatients below the age of 15. Newborn cribs and bassinets are excluded from this definition.

"Inpatient beds" means accommodations within a medical care facility with continuous support services (such as food, laundry, housekeeping) and staff to provide health or health-related services to patients who generally remain in the

medical care facility in excess of 24 hours. Such accommodations are known by various nomenclatures including but not limited to; nursing facility beds, intensive care beds, minimal or self care beds, insolation beds, hospice beds, observation beds equipped and staffed for overnight use, and obstetric, medical surgical, psychiatric, substance abuse, medical rehabilitation and pediatric beds including pediatric bassinets and incubators. Bassinets and incubators in the maternity department and beds located in labor and birthing rooms, emergency rooms, preparation or anesthesia inductor rooms, diagnostic or treatment procedure rooms, or on-call staff rooms are excluded from this definition.

"Intensive care beds" means acute inpatient beds that are located in the following units or categories:

1. General intensive care units (ICU) means those units in which patients are concentrated, by reason of serious illness or injury, without regard to diagnosis. Special lifesaving techniques and equipment are immediately available, and patients are under continuous observation by nursing staff specially trained and selected for the care of this class of patient;
2. Cardiac care units (CCU) means special units staffed and equipped solely for the intensive care of cardiac patients;
3. Specialized intensive care units (SICU) means any units with specialized staff and equipment for the purpose of providing care to seriously ill or injured patients for selected categories of diagnoses. Examples include units established for burn care, trauma care, neurological care, pediatric care, and cardiac surgery recovery. This category of beds does not include neonatal intensive care units; and
4. Progressive care units (PCU) means any units which have been established to care for seriously ill or injured patients who do not require the continuous level of care available in an intensive care unit but whose conditions require monitoring at a level which is generally not available in a general medical/surgical bed.

"Licensed bed" means those inpatient care beds licensed by the department's Office of Health Facilities regulation.

~~*"Metropolitan statistical area (MSA)"* means a general concept of a metropolitan area that consists of a large population nucleus together with adjacent communities which have a high degree of economic and social integration with the nucleus. Each MSA has one or more central counties containing the area's main population concentration: an urbanized area with at least 50,000 inhabitants. An MSA may also include outlying counties which have close economic and social relationships with the central counties. The outlying counties must have a specified level of commuting to the central counties and and must also meet standards regarding metropolitan character, such as population density, urban population, and population growth.~~

"Nursing facility beds" means inpatient beds which are located in distinct units of acute inpatient facilities which are licensed as long-term care units by the department. Beds in these long-term units are not included in the calculations of acute inpatient bed need.

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"Off-site replacement" means the movement of existing beds off of the existing site of an acute care inpatient facility.

"Planning horizon year" means the particular year for which beds are projected to be needed.

"Relevant reporting period" means the most recent 12 month period, prior to the beginning of the Certificate of Public Need application's review cycle, for which data is available and acceptable to the department.

"Skilled nursing units (SNF)" means those units which provide patient care at a level of care below that normally required in an acute care setting and greater than that of an intermediate care nursing facility. Although such units often have lengths of stays of less than 30 days, they are considered nursing facility beds and are excluded in calculations of acute care inpatient bed need.

"Staffed beds" means that portion of the licensed or approved beds that are immediately available to be occupied. Beds which are not available due to lack of staffing or renovation are excluded from this category.

12 VAC 5-240-20. Accessibility.

Acute care inpatient facility beds should be within ~~45~~ 30 minutes ~~average~~ driving time, under normal conditions, of 90% of the population of a planning district.

Providers of acute care inpatient facility services serving rural areas should facilitate the transport of patients residing in rural areas to needed medical care facilities and services, directly or through coordinated efforts with other organizations. Preference will be given in the review of competing applications to applicants who can document a history and commitment to development of transportation resources for rural populations.

12 VAC 5-240-30. Availability.

A. Need for new service.

1. No new acute inpatient care beds should be approved in any planning district unless the resulting number of licensed and approved beds in a planning district does not exceed the number of beds projected to be needed, for each acute inpatient bed category, for that planning district for the fifth planning horizon year.

2. Notwithstanding the need for new acute inpatient care beds above, no proposals to increase the general medical/surgical and pediatric bed capacity in a planning district should be approved unless the average annual occupancy, based on the number of licensed beds in the planning district where the project is proposed, is at least 85% for the relevant reporting period.

3. Notwithstanding the need for new acute inpatient beds above, no proposals to increase the intensive care bed capacity in ~~a metropolitan statistical area~~ a nonrural area should be approved unless: (i) the average annual occupancy rate, based on the number of licensed beds in the ~~MSA~~ nonrural area where the project is proposed, is at least 65% for the relevant reporting period; or (ii) for hospitals ~~outside of an MSA~~ in rural areas, the number of beds projected to be needed to provide 99% probability that

adequate bed capacity will exist for all unscheduled admissions, exceeds the number of licensed beds projected for the fifth planning horizon year.

B. Off-site replacement of existing services.

1. No proposal to replace acute care inpatient beds off-site, to a location not contiguous to the existing site, should be approved unless: (i) off-site replacement is necessary to correct life safety or building code deficiencies; (ii) the population served by the beds to be moved will have reasonable access to the acute care beds at the new site, or the population served by the facility to be moved will generally have comparable access to neighboring acute care facilities; and (iii) the beds to be replaced experienced an average annual utilization of 85% for general medical/surgical beds and 65% for intensive care beds in the relevant reporting period.

2. The number of beds to be moved off-site must be taken out of service at the existing facility.

3. The off-site replacement of beds should result in a decrease in the licensed bed capacity of the applicant facility(ies) or substantial cost savings, cost avoidance, consolidation of underutilized facilities, or in other ways improve operation efficiency, or improvements in the quality of care delivered over that experienced by the applicant facility(ies).

C. Alternative need for the conversion of underutilized licensed bed capacity. For proposals involving a capital expenditure of \$1 million or more, and involving the conversion of underutilized licensed bed capacity to either medical/surgical, pediatric or intensive care, consideration will be given to the approval of the project if: (i) there is a projected need for the category of acute inpatient care beds that would result from the conversion; and (ii) it can be reasonably demonstrated that the average annual occupancy of the beds to be converted would reach the standard in subdivision B 1 of this section for the bed category that would result from the conversion, by the first year of operation.

D. Computation of the need for general medical/surgical and pediatric beds.

1. A need for additional acute care inpatient beds may be demonstrated if the total number of licensed and approved beds in a given category in the planning district where the proposed project will be located is less than the number of such beds that are projected as potentially necessary to meet demand in the fifth planning horizon year from the year in which the application is submitted.

2. The number of licensed and approved general medical/surgical beds will be based on the inventory presented in the most recent edition of the State Medical Facilities Plan or amendment thereof, and may also include subsequent reductions in or additions to such beds for which documentation is available and acceptable to the department. The number of general medical/surgical beds projected to be needed in the planning district shall be computed using the following method:

a. Determine the projected total number of general medical/surgical and pediatric inpatient days for the fifth planning horizon year as follows:

- (1) Sum the medical/surgical and pediatric unit inpatient days for the past three years for all acute care inpatient facilities in the planning district as reported in the Annual Survey of Hospitals;
- (2) Sum the planning district projected population for the same three year period as reported by the Virginia Employment Commission;
- (3) Divide the sum of the general medical/surgical and pediatric unit inpatient days by the sum of the population and express the resulting rate in days per 1,000 population;
- (4) Multiply the days per 1,000 population rate by the projected population for the planning district (expressed in 1,000s) for the fifth planning horizon year.

b. Determine the projected number of general medical/surgical and pediatric unit beds which may be needed in the planning district for the planning horizon year as follows:

- (1) Divide the result in subdivisions D 2 a (4) (number of days projected to be needed) by 365;
- (2) Divide the quotient obtained by *.85 in planning districts in which 50% or more of the population resides in nonrural areas and .75 in planning districts in which less than 50% of the population resides in nonrural areas.*

c. Determine the projected number of general medical/surgical and pediatric beds which may be established or relocated within the planning district for the fifth planning horizon year as follows:

- (1) Determine the number of licensed and approved medical/surgical and pediatric beds as reported in the inventory of the most recent edition of the State Medical Facilities Plan, available data acceptable to the department;
- (2) Subtract the number of beds identified in *subdivision 2 a above of this subsection* from the number of beds needed as determined in *subdivision 2 b (2) of this subsection*. If the difference indicated is positive, then a need may be determined to exist for additional general medical/surgical or pediatric beds. If the difference is negative, then no need shall be determined to exist for additional beds.

E. Computation of need for distinct pediatric units.

1. Beds used to form pediatric units must be taken from the inventory of general medical/surgical beds of a facility if need for additional such beds cannot be demonstrated.
2. Should a hospital desire to establish or expand a distinct pediatric unit within its licensed bed capacity, the following methodology shall be used to determine the appropriate size:

a. Determine the utilization of the individual hospital's inpatient days by persons under 15 years of age:

- (1) Sum the general medical/surgical (including pediatric unit) inpatient days for the past three years for all patients under 15 years of age from hospital discharge abstracts;
- (2) Sum the planning district projected population for the 0 to 14 age group for the same three year period as reported by the Virginia Employment Commission;
- (3) Divide the sum of the general medical/surgical days by the sum of the population and express the resulting rate in days per 1,000 population;
- (4) Multiply the days per 1,000 population rate by the projected population age 0 to 14 for the planning district (expressed in 1,000s) for the fifth planning horizon year to yield the projected pediatric patient days;
- (5) Divide the patient days by 365 to yield the projected average daily census (PADC);
- (6) Calculate the number of beds needed to assure that adequate bed capacity will exist with a 99% probability for an unscheduled pediatric admission using the following formula:

$$\text{Number of pediatric beds allowable} = \text{PADC} + 2.33\sqrt{\text{PADC}}$$

F. Computation of need for intensive care beds.

1. The number of licensed and approved intensive care beds will be based on the inventory presented in the most recent edition of the State Medical Facilities Plan or amendment thereof, and may also include subsequent reductions in or additions to such beds for which documentation is available and acceptable to the department.
2. The number of intensive care beds projected to be needed in the planning district shall be computed using the following method:

~~4.~~ a. Determine the projected total number of intensive care inpatient days for the fifth planning horizon year as follows:

- ~~a.~~ (1) Sum the intensive care inpatient days for the past three years for all acute care inpatient facilities in the planning district as reported in the annual survey of hospitals;
- ~~b.~~ (2) Sum the planning district projected population for the same three-year period as reported by the Virginia Employment Commission;
- ~~c.~~ (3) Divide the sum of the intensive care days by the sum of the population and express the resulting rate in days per 1,000 population;
- ~~d.~~ (4) Multiply the days per 1,000 population rate by the projected population for the planning district (expressed in 1,000s) for the fifth planning horizon year to yield the expected intensive care patient days.

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~~2-~~ b. Determine the projected number of intensive care beds which may be needed in the planning district for the planning horizon year as follows:

~~a-~~ (1) Divide the number of days projected in ~~4-d~~ subdivision 2 a (4) of this subsection by 365 to yield the projected average daily census (PADC);

~~b-~~ (2) Calculate the beds needed to assure with 99% probability that an intensive care bed will be available for the unscheduled admission:

$$\text{Number of pediatric beds allowable} = \text{PADC} + 2.33\sqrt{\text{PADC}}$$

~~3-~~ c. Determine the projected number of intensive care beds which may be established or relocated within the planning district for the fifth planning horizon year as follows:

~~a-~~ (1) Determine the number of licensed and approved intensive care beds as reported in the inventory of the most recent edition of the State Medical Facilities Plan, an amendment thereof, or the inventory after subsequent documented reductions or additions have been determined by the department.

~~b-~~ (2) Subtract the number of licensed and approved beds identified in ~~3-a above~~ subdivision 2 c (1) of this subsection from the number of beds needed as determined in subdivision 2 b (2) of this subsection. If the difference indicated is positive, then a need may be determined to exist for additional intensive care beds. If the difference is negative, then no need shall be determined to exist for additional beds.

12 VAC 5-250-30. Accessibility; travel time; financial considerations.

A. Consistent with minimum size and use standards delineated below, basic obstetrical services should be available within one hour average travel time of 95% of the population in rural areas and within 30 minutes average travel time in urban and suburban areas.

B. Obstetrical and related services should be open to all without regard to ability to pay or payment source.

C. Providers of obstetrical facility services serving rural areas should facilitate transport of patients residing in rural areas to needed obstetrical facility services, directly or through coordinated efforts with other organizations. Preference will be given in the review of competing applications to applicants who can demonstrate a commitment to the development of transportation resources for rural populations.

12 VAC 5-260-30. Accessibility; financial considerations.

A. Adult cardiac catheterization services should be accessible within a one hour driving time, under normal conditions, for 90% of Virginia's population.

B. Cardiac catheterization services should be accessible to all patients in need of services without regard to their ability to pay or the payment source.

C. Providers of cardiac catheterization services serving rural areas should facilitate the transport of patients residing in rural areas to needed cardiac catheterization services, directly or through coordinated efforts with other organizations. Preference will be given in the review of competing applications to applicants who can demonstrate a history of commitment to the development of transportation resources for rural populations.

12 VAC 5-260-40. Availability; need for new services; alternatives.

A. Need for new service. No new cardiac catheterization service should be approved unless (i) all existing cardiac catheterization laboratories located in the planning district in which the proposed new service will be located where used for at least 960 diagnostic-equivalent cardiac catheterization procedures for the relevant reporting period; and (ii) it can be reasonably projected that the proposed new service will perform at least 200 diagnostic equivalent procedures in the first year of operation, 500 diagnostic equivalent procedures in the second year of operation, and 800 diagnostic equivalent procedures in the third year of operation without reducing the utilization of existing laboratories in the planning district such that less than 960 diagnostic equivalent procedures are performed at any of those existing laboratories.

B. Mobile cardiac catheterization service. Proposals for the use of freestanding or mobile cardiac catheterization services should only be approved if such services will be provided at a site located on the campus of a general/community hospital and complies with all applicable sections of the state medical facilities plan as determined by the department.

C. Alternative need for new services in ~~remote rural~~ areas. Notwithstanding the standards for approval of new cardiac catheterization services outlined above, consideration will be given to the approval of new cardiac catheterization services which will be located at a general hospital located 60 minutes or more driving time, under normal conditions, from any site at which cardiac catheterization services are available if it can be reasonably projected that the proposed new services will perform at least 200 diagnostic-equivalent procedures in the first year of operation, 400 diagnostic-equivalent procedures in the second year of operation, and 600 diagnostic-equivalent procedures in the third year of operation without reducing the utilization of existing laboratories located within 60 to 70 minutes driving time, under normal conditions, from the proposed new service location.

D. Need for expanded service. Proposals for the expansion of cardiac catheterization services should not be approved unless all existing cardiac catheterization laboratories operated by the applicant have performed at least 1,200 diagnostic-equivalent cardiac catheterization procedures for the relevant reporting period, and it can be reasonably demonstrated that the expanded cardiac catheterization service will achieve a minimum of 200 diagnostic equivalent procedures per laboratory to be added in the first 12 months of operation, 400 diagnostic equivalent procedures in the second 12 months of operation, and 600 procedures per laboratory in the third year of operation, without reducing the utilization of existing cardiac catheterization laboratories in the planning district below 960 diagnostic equivalent procedures.

E. Replacement.

1. Proposals for the replacement of existing cardiac catheterization services should not be approved unless the equipment to be replaced has been in service for at least five years and; (i) in the case of providers located within 60 minutes driving time, under normal conditions, of alternative cardiac catheterization services, the equipment to be replaced has been used in the performance of at least 960 diagnostic-equivalent cardiac catheterization procedures in the relevant reporting period; or (ii) in the case of providers located beyond 60 minutes driving time, under normal conditions, of alternative cardiac catheterization services, the equipment to be replaced has been used in the performance of at least 600 diagnostic-equivalent cardiac catheterization procedures in the relevant reporting period.

2. Additionally, all proposals for replacement of cardiac catheterization services should comply with all applicable sections of this state medical facilities plan component, as determined by the department.

F. Emergency availability. Cardiac catheterization services should be available for emergency cardiac catheterization within 30 minutes or less at all times.

G. Pediatric services. No new or expanded pediatric cardiac catheterization services should be approved unless the proposed new or expanded service will be provided at: (i) a hospital that also provides open heart surgery services, provides pediatric tertiary care services, has a pediatric intensive care unit and provides neonatal special care; or (ii) a hospital that is a regional perinatal center, has a cardiac intensive care unit and provides open heart surgery services; and it can be reasonably demonstrated that each proposed laboratory will perform at least 100 pediatric cardiac catheterization procedures in the first year of operation, 200 pediatric cardiac catheterization procedures in the second year of operation and 400 pediatric cardiac catheterization procedures in the third year of operation.

H. Emergency availability of open heart surgery. No application for new, expanded, or replacement cardiac catheterization services which includes the provision or potential provision of PTCA, transseptal puncture, transthoracic left ventricular puncture, or myocardial biopsy services should be approved unless emergency open heart surgery services are, or will be available on-site at all times at the same hospital at which the proposed new, expanded, or replacement cardiac catheterization service will be located.

12 VAC 5-260-80. Acceptability; consumer participation.

A. The waiting time for elective open heart surgery procedures should be less than one month.

B. Providers of open heart surgery should provide a program of patient and family education regarding the nature of the patient's heart disease, and which attempts to assure the family and the patient's joint compliance in the post-operative management of the patient.

The patient and his family should be fully informed and involved in the decision-making regarding the open heart surgery.

C. Providers of open heart surgery services should have in place a mechanism for identifying travel and housing problems for patients and their families, *particularly in rural areas*, and provide assistance in making arrangements for these services for those patients and their families who may need them during the period of surgery and post-operative management.

12 VAC 5-260-100. Availability; need for the new service; alternatives.

A. Need for the new service. No new open heart services should be approved unless: (i) the service is to be made available in a general hospital which has established cardiac catheterization services that have been used for the performance of at least 960 diagnostic-equivalent procedures for the relevant reporting period and has been in operation for at least 30 months; (ii) all existing open heart surgery rooms located in the planning district in which the proposed new service will be located have been used for at least 400 adult-equivalent open heart surgical procedures for the relevant reporting period; and (iii) it can be reasonably projected that the proposed new service will perform at least 150 adult-equivalent procedures in the first year of operation, 250 adult-equivalent procedures in the second year of operation, and 400 adult-equivalent procedures in the third year of operation without reducing the utilization of existing open heart surgery programs in the planning district such that less than 400 adult-equivalent open heart procedures are performed at those existing laboratories.

B. Alternative need for new services in ~~remote~~ *rural* areas. Notwithstanding the standards for approval of new open heart services outlined above, consideration will be given to the approval of new open heart surgery services which will be located at a general hospital located more than two hours driving time, under normal conditions, from any site at which open heart surgery services are available if it can be reasonably projected that the proposed new service will perform at least 150 adult-equivalent open heart procedures in the first year of operation, 225 adult-equivalent procedures in the second year of operation, and 300 adult-equivalent procedures in the third year of operation without reducing the utilization of existing open heart surgery rooms within a 120-150 minute driving time, under normal conditions, from the proposed new service location below 400 adult-equivalent open heart surgical procedures per room. Such hospitals should also have provided at least 760 diagnostic-equivalent cardiac catheterization procedures during the relevant reporting period on equipment which has been in operation at least 30 months.

C. Need for expanded service. Proposals for the expansion of open heart surgery services should not be approved unless all existing open heart surgery rooms operated by the applicant have performed at least 400 adult-equivalent open heart surgery procedures in the relevant reporting period if the facility is within two hours driving time, under normal conditions, of an existing open heart surgery service, or at least 300 adult-equivalent open heart surgery procedures in the relevant reporting period if the facility that proposes expanded-services is in excess of two hours driving time,

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under normal conditions, of an existing open heart surgery service.

Additionally, all proposals for the expansion of open heart surgery services should comply with all applicable sections of this State Medical Facilities Plan component, as determined by the department.

D. Replacement. Proposals for the replacement of existing open heart surgery services should not be approved unless the equipment to be replaced has been in operation for at least 30 months; and (i) in case of providers located within two hour's driving time, under normal conditions, of alternative open heart surgery services, the open heart surgery equipment to be replaced has been used in the performance of at least 400 adult-equivalent procedures in the relevant reporting period; or (ii) in the case of providers located beyond two hour's driving time, under normal conditions, of alternative open heart surgery services, the open heart surgery room to be replaced has been used in the performance of at least 300 adult-equivalent procedures in the relevant reporting period.

Additionally, all proposals for the replacement of open heart surgery services should comply with all the applicable sections of the State Medical Facilities Plan component, as determined by the department.

E. Pediatric services. No new, expanded or replacement pediatric open heart surgery service should be approved unless the proposed new, expanded or replacement service is provided at a hospital that: (i) has cardiac catheterization services which have been in operation for 30 months and that have been used in the performance of at least 200 pediatric cardiac catheterization procedures for the relevant reporting period, provides pediatric tertiary care services, has pediatric intensive care services and provides neonatal special care; or (ii) is a regional perinatal center and has a cardiac intensive care unit.

12 VAC 5-270-30. Accessibility; travel time; financial.

Surgical services should be available within a maximum driving time, under normal conditions, of 45 30 minutes for 90% of the population of a planning district.

Surgical services should be accessible to all patients in need of services without regard to their ability to pay or the payment source.

Providers of surgical services serving rural areas should facilitate the transport of patients residing in rural areas to needed surgical services, directly or through coordinated efforts with other organizations. Preference will be given in the review of competing applications to applicants who can demonstrate a history of commitment to the development of transportation resources for rural populations.

12 VAC 5-270-40. Availability; need.

A. Need.

The combined number of inpatient and ambulatory surgical operating rooms needed in a planning district will be determined as follows:

1. $CSUR = ORV/POP$

Where CSUR is the current surgical use rate in a planning district as calculated in the above formula;

ORV is the sum of total operating room visits (inpatient and outpatient) in the planning district in the most recent three consecutive years for which operating room utilization data has been reported by the Virginia Center for Health Statistics; and

POP is the sum of total population in the planning district in the most recent three consecutive years for which operating room utilization data has been reported by the Virginia Center for Health Statistics, as found in the most recent published projections of the Virginia Employment Commission.

2. $PORV = CSUR * PROPOP$

Where PORV is the projected number of operating room visits in the planning district three years from the current year; and

PROPOP is the projected population of the planning district three years from the current year as reported in the most recent published projections of the Virginia ~~Economic~~ Employment Commission.

3. $FORH = PORV * AHORV$

Where FORH is future operating room hours needed in the planning district three years from the current year; and

AHORV is the average hours per operating room visit in the planning district for the most recent year for which average hours per operating room visit as been calculated from information collected by the Virginia Department of Health.

4. $FOR = FORH/1600$

Where FOR is future operating rooms needed in the planning district three years from the current year.

No additional operating rooms should be authorized for a planning district if the number of existing or authorized operating rooms in the planning district is greater than the need for operating rooms identified using the above methodology. New operating rooms may be authorized for a planning district up to the net need identified by subtracting the number of existing or authorized operating rooms in the planning district from the future operating rooms needed in the planning district, as identified using the above methodology.

Consideration will be given to the addition of operating rooms by existing medical care facilities in planning districts with an excess supply of operating rooms, based on the methodology outlined above, when such addition can be justified on the basis of facility-specific utilization or geographic remoteness (driving time of 45 minutes or more, under normal conditions, to alternative surgical facilities).

B. Relocation. Projects involving the relocation of existing operating rooms within a planning district may be authorized when it can be reasonably documented that such relocation will: (i) improve the distribution of surgical services within a planning district; or (ii) result in the provision of the same

surgical services at a lower cost to surgical patients in the planning district; or (iii) optimize the number of operations in the planning district which are performed on an ambulatory basis.

C. Ambulatory surgical facilities. Preference will be given to the development of needed operating rooms in dedicated ambulatory surgical facilities developed within general hospitals or as freestanding centers owned and operated by general hospitals.

12 VAC 5-280-10. Definitions.

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Department" means Virginia Department of Health.

"Donor organ/organ system" means an organ/organ system retrieved from a cadaver or living donor, and processed under appropriate rules and protocols, for the purpose of surgical transplantation into a recipient selected in accordance with established guidelines and protocols.

"Health care financing administration (HCFA) Medicare requirements" means those clinical, certification and administrative requirements and standards set by the HCFA of the United State Department of Health and Human Services to establish eligibility for Medicare program reimbursement.

"Minimum survival rates" means the lowest percentage of those receiving transplants who survive at least one year or for such other periods of times as specified by the department. Minimum survival rates not specified in these standards shall be established by the department as experience permits.

"Minimum utilization" means the number of transplants expected to be performed annually. Minimum utilization requirements not specified in these standards shall be established by the department as experience permits.

"Organ/organ system" means any of the number of clinically distinct components of the human body containing tissues performing a function for which it is especially adapted. Distinct organ/organ systems include, but are not limited to, kidney, heart, heart/lung, liver, and pancreas.

"Organ transplantation" means a set of medical procedures performed to remove surgically a defined diseased or nonfunctioning organ/organ system from a patient and replace it with a healthier functioning donor organ/organ system.

"Satellite clinic" means a scheduled program of outpatient services for pre- or post-transplant patients, or both, conducted at a site remote from the facility in which the organ transplant surgical services are provided that allows patients to obtain outpatient services associated with organ transplantation closer to their city or county of residence.

12 VAC 5-280-30. Accessibility; travel time; access to available organs.

A. Organ transplantation services, of any type, should be accessible within two hours driving time, under normal conditions, of 95% of Virginia's population.

B. Providers of organ transplantation services should demonstrate to the satisfaction of the department that they have clearly defined patient/organ recipient policies based solely on medical criteria.

C. Providers of organ transplantation services should facilitate access to pre- and post-transplantation services needed by patients residing in distant locations by establishing part-time satellite clinics.

12 VAC 5-280-70. Quality; minimum utilization; minimum survival rate; service proficiency; staffing; systems operations; support services.

A. 1. Proposals to establish, expand or replace organ transplantation services should demonstrate that a minimum number of transplants will be performed annually. The minimum number required by organ system is:

| | |
|------------|-------|
| Kidney | 25 |
| Heart | 12 |
| Heart/Lung | 12 |
| Liver | 42 20 |
| Pancreas | 12 |

2. Successful transplantation programs are expected to perform substantially larger numbers of transplants annually. Performance of minimum transplantation volumes does not necessarily indicate a need for additional transplantation capacity or programs.

3. Preference will be given to expansion of successful existing services, either by enabling necessary increases in the number of organ systems being transplanted or by adding transplantation capability for additional organ systems, rather than developing other programs that could reduce average program volume.

B. 1. Facilities should demonstrate that they will achieve and maintain minimum transplant patient survival rates. Minimum one year survival rates, listed by organ system, are:

| | |
|------------|------------|
| Kidney | 90-95% |
| Heart | 70-80% |
| Heart/Lung | (none set) |
| Liver | 50-60% |
| Pancreas | 80-90% |

2. Survival rates beyond one year should be consistent with the Health Care Financing Administration (HCFA) Medicare program requirements, or with applicable professional society recommended standards acceptable to the department where there are no HCFA criteria.

C. Proposals to add additional organ transplantation services should demonstrate at least two years successful experience with all existing organ transplantation systems.

D. 1. All physicians that perform transplants should be board certified by the appropriate professional examining board, and should have a minimum of one year of formal training and two years of experience in transplant surgery and post-operative care.

2. Organ transplantation services should have a complete team of surgical, medical and other specialists, with at least

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two years experience in the proposed organ transplantation system.

E. 1. Providers of organ transplantation services should document that they participate in a regional and national organ donor network. The facility should have written policies and procedures governing organ and tissue procurement.

2. Providers of organ transplantation services should have an ongoing approved medical education program.

3. Providers of organ transplantation services should collect and submit to the department transplantation program operating statistics, including patient and procedure volumes, mortality data and program cost and charges.

F. Providers of organ transplantation services should demonstrate that they have direct and immediate access to a histocompatibility testing laboratory that meets the American Society for Histocompatibility and Immunogenetics (ASHI) standards.

12 VAC 5-290-10. Definitions.

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise:

"Acute psychiatric services" are inpatient psychiatric services provided at the hospital level of care which have a reported inpatient average length of stay of 90 days or less.

"Acute substance abuse treatment services" are inpatient substance abuse treatment services provided at the hospital level of care, exemplified by medical detoxification, treatment of the medical and psychiatric complications of chemical dependency, and continuous nursing services.

"Inpatient psychiatric services" are acute psychiatric services provided through distinct inpatient units of medical care facilities or through free-standing psychiatric hospitals. Inpatient psychiatric beds are licensed by the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS). *"Psychiatric services"* are services provided to individuals for the prevention, diagnosis, treatment, and/or palliation of psychiatric disorders.

"Inpatient substance abuse treatment services" are substance abuse treatment services provided through distinct inpatient units of medical care facilities or through free-standing inpatient substance abuse treatment facilities. Inpatient substance abuse treatment beds are licensed by the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS).

"Intermediate care substance abuse treatment services" are inpatient substance abuse treatment services provided at the residential level of care, exemplified by sub-acute (nonhospital) detoxification services and structured programs of assessment, counseling, vocational rehabilitation, and social rehabilitation.

"Long term psychiatric services" are inpatient psychiatric services provided at the hospital level of care which have a reported inpatient average length of stay in excess of 90 days. These services have traditionally been provided in facilities

operated by the DMHMRSAS and, in that case, have not been subject to certificate of public need requirements.

"Satellite clinic" means a scheduled program of outpatient services for patients requiring psychiatric or substance abuse treatment following discharge from an inpatient program conducted at a site remote from the facility in which the inpatient services are provided that allows patients to obtain needed outpatient services for their psychiatric illness or substance abuse, or both, closer to their city or county of residence.

"Substance abuse treatment services" are services provided to individuals for the prevention, diagnosis, treatment, and/or palliation of chemical dependency, which may include attendant medical and psychiatric complications of chemical dependency.

12 VAC 5-290-30. Accessibility; travel time; financial considerations.

A. Acute psychiatric, acute substance abuse treatment, and intermediate care substance abuse treatment services should be available within a maximum driving time, under normal conditions, of 60 minutes one-way for 95% of the population.

B. 1. Acute psychiatric, acute substance abuse treatment, and intermediate care substance abuse treatment services should be accessible to all patients in need of services without regard to their ability to pay or the payment source.

2. Existing and proposed acute psychiatric, acute substance abuse treatment, and intermediate care substance abuse treatment service providers should have established plans for the provision of services to indigent patients which include, at a minimum: (i) the number of unreimbursed patient days to be provided to indigent patients who are not Medicaid recipients; (ii) the number of Medicaid-reimbursed patient days to be provided (unless the existing or proposed facility is ineligible for Medicaid participation); (iii) the number of unreimbursed patient days to be provided to local community services boards; and (iv) a description of the methods to be utilized in implementing the indigent patient service plan and assuring the provision of the projected levels of unreimbursed and Medicaid-reimbursed patient days. The definition of indigent person used in the indigent patient service plan should be consistent with the definition of charity care used by Virginia's Indigent Care Trust Fund.

3. Proposed acute psychiatric, acute substance abuse treatment, and intermediate care substance abuse treatment service providers should have formal agreements with community services boards in their identified service area which: (i) specify the number of charity care patient days which will be provided to the community service board; (ii) provide adequate mechanisms for the community services board to monitor compliance with charity care provisions; and (iii) provide for effective discharge planning for all patients (to include the return of patients to their place of origin/home state if other than Virginia).

C. Providers of acute psychiatric, acute substance abuse treatment, and intermediate care substance abuse treatment services serving large geographic areas should establish

satellite outpatient facilities to improve patient access, where appropriate and feasible.

12 VAC 5-300-30. Availability; need.

The establishment of new ICF/MR facilities should not be authorized unless the following conditions are met:

1. Alternatives to the service proposed to be provided by the new ICF/MR are not available in the area to be served by the new facility;
2. There is a documented source of resident referrals for the proposed new facility;
3. The applicant can identify the manner in which the proposed new facility fits into the continuum of care for the mentally retarded;
4. There are ~~specific local conditions which~~ *distinct and unique geographic, socioeconomic, cultural, transportation, or other factors affecting access to care that* require development of a new ICF/MR;
5. Alternatives to the development of a new ICF/MR consistent with the Medicaid waiver program have been considered and can be reasonably discounted in evaluating the need for the new facility.
6. The proposed new facility is consistent with the current DMHMRSAS Comprehensive Plan and the mental retardation service priorities for the catchment area identified in the plan;
7. Ancillary and supportive services needed for the new facility are available; and
8. Service alternatives for residents of the proposed new facility who are ready for discharge from the ICF/MR setting are available.

12 VAC 5-310-30. Accessibility; travel time; financial considerations.

A. Comprehensive inpatient rehabilitation services should be available within a maximum driving time, under normal conditions, of 60 minutes for 95% of the population.

B. Medical rehabilitation services should be accessible to all patients in need of services without regard to their ability to pay.

C. Providers of comprehensive medical rehabilitation services should facilitate access to outpatient medical rehabilitation services for discharged patients residing in remote or rural areas, directly or through the establishment of referral linkages with general hospitals or other appropriate organizations.

12 VAC 5-320-50. Need for new service.

A. Preference will be given to proposals involving the provision of full-body CT scanning rather than units which can perform only CT head scans.

B. No CT service should be approved at a site which is within 30 minutes driving time of: (i) a COPN approved or exempted CT service that is not yet operational; or (ii) an existing CT unit that has performed fewer than 3,500 HECTs or 3,000

combined CT head and body scans during the relevant reporting period.

C. A proposed new CT service may be approved if: (i) in the case of a proposed stationary, hospital-based service, the applicant provides diagnostic-specific hospital discharge data for the relevant reporting period that is acceptable to the department which demonstrates that the HECTs attributable to the patient mix of the hospital where the proposed CT is to be located equates to at least 3,500 HECTs; or (ii) in the case of a proposed nonhospital-based service, the applicant demonstrates that the number of outpatient studies performed by other CT services on the applicant's patients during the relevant reporting period is at least 3,500 HECTs or 3,000 combined CT head and body scans.

Consideration will be given to approval of CT services that project fewer than 3,500 HECTs or 3,000 combined CT head and body scans when such services are proposed for sites located beyond 30 minutes driving time of any existing CT facilities.

D. No new, nonhospital-based CT service or network may be approved unless all existing CT services or networks in the planning district, whether hospital-based, nonhospital-based, mobile or fixed, performed an average of at least 5,000 HECTs or 4,500 combined CT head and body scans per machine during the relevant reporting period.

12 VAC 5-320-150. Need for new service.

A. Preference will be given to applications which intend to provide hospital-based MRI services.

B. No MRI service should be approved at a site which is within 45 minutes driving time of: (i) a COPN approved or exempted MRI service that is not yet operational; or (ii) an existing MRI service that has performed fewer than 3,500 MRI scans or at least 3,000 MRI scans excluding those performed on behalf of the applicant during the relevant reporting period.

Consideration will be given to approval of proposed MRI services that project less than full utilization of MRI equipment when such services are proposed for sites located beyond 45 minutes driving time of any existing MRI facilities.

12 VAC 5-320-430. Introduction of SPECT as a new service.

Any applicant establishing a specialized center, clinic, or portion of a physician's office for the provision of SPECT or introducing SPECT as a new service at an existing medical care facility which has not previously provided nuclear medicine imaging services should provide documentation satisfactory to the department that it can achieve a minimum utilization level of 650 SPECT scans in the first 12 months of operation of the service, and 1,000 such procedures in the second 12 months of services if the imaging unit would be a single-head device; or that it can achieve a minimum utilization level of 1,000 SPECT scans in the first 12 months of operation of the service, 1,250 such procedures in the second 12 months of operation, and 1,500 such procedures in the third 12 months of operation if the imaging unit would be a multi-head device.

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Consideration will be given to the approval of proposed nuclear medicine imaging services that project utilization below that outlined in the preceding paragraph when such services are proposed for sites located beyond 45 minutes driving time of any existing nuclear medicine imaging facilities.

12 VAC 5-340-30. Accessibility; time; financial considerations.

A. 1. Radiation therapy services should be available within the institution, on a regularly scheduled basis, for a minimum of 40 hours a week.

2. Convenient hours of operation should be provided for the benefit of outpatients (early morning hours, lunch hours, evening hours, weekends).

B. Radiation therapy services should be available within one hour normal driving time, under normal conditions, for 95% of the population.

C. Radiation therapy services should be accessible to all patients in need of services without regard to their ability to pay or the payment source.

D. Providers of radiation therapy services serving rural areas should facilitate the transport of patients residing in rural areas to needed radiation therapy services, directly or through coordinated efforts with other organizations. Preference will be given in the review of competing applications to applicants who can demonstrate a history of commitment to the development of transportation resources for rural populations.

12 VAC 5-360-30. Accessibility.

A. Travel time. Nursing home beds should be accessible within a 45 minute driving time, under normal conditions, to 90% of all Virginians. Preference will be given in the review of competing applications to proposed nursing home facilities which substantively improve geographic access and reduce travel time to nursing home services within a planning district.

B. Access to highway system. Nursing home facilities should be linked by paved roads to a state or federal highway and should be accessible by public transportation, when such systems exist in an area. ~~In urban areas, preference will be given in the review of competing applications to proposed nursing facilities which are fully accessible by private and public modes of transportation.~~

C. Financial. Nursing home services should be accessible to all persons in need of such services without regard to their ability to pay or the payment source. Preference will be given in the review of competing applications to proposed nursing facilities which will be accessible to all persons in need of such services without regard to their ability to pay or the payment source and can demonstrate a record of such accessibility.

D. Distribution of beds. Preference will be given in the review of competing applications to proposals which correct any maldistribution of beds within a planning district.

12 VAC 5-360-40. Availability.

A. Need for additional nursing home beds. No planning district will be considered to have a need for additional nursing home

facility beds unless: (i) the bed need forecast for nursing home beds in that planning district (see subsection C of this section) exceeds the current inventory of nonfederal licensed and authorized beds in that planning district; and (ii) the estimated average annual occupancy of all existing *nonfederal* Medicaid-certified nursing facility beds in the planning district was at least 95% for the most recent three years for which bed utilization has been reported to the department. (The bed inventory and utilization of the Virginia Veterans Care Center will be excluded from consideration in the determination of nursing home facility bed need.)

No planning district will be considered to have a need for additional nursing home beds if there are uncompleted nursing facility beds authorized for the planning district that will be Medicaid-certified beds.

B. Expansion of existing nursing facilities. Proposals for the expansion of existing nursing facilities should not be approved unless the facility has operated for at least three years and average annual occupancy of the facility's existing beds was at least 95% in the most recent year for which bed utilization has been reported to the department.

Exceptions to this standard will be considered for facilities that have operated at less than 95% average annual occupancy in the most recent year for which bed utilization has been reported to the department when the facility can demonstrate that it has a rehabilitative or other specialized care focus which results in a relatively short average length of stay and, consequently, cannot achieve an average annual occupancy rate of 95%.

Preference will be given in the review of competing applications to proposals which involve the expansion of freestanding nursing home facilities of 60 or fewer beds when such facilities can demonstrate substantial compliance with the standards of the State Medical Facilities Plan.

In a case where no competing applicant is a freestanding nursing home facility with 60 or fewer beds or where freestanding nursing homes of 60 or fewer and 61 to 90 beds are competing, preference will also be given in the review of competing applications to proposals which involve the expansion of freestanding nursing home facilities of 90 or fewer beds when such facilities can demonstrate substantial compliance with the standards of the State Medical Facilities Plan.

C. Bed need forecasting method. The number of nursing home facility beds forecast to be needed in a given planning district will be computed as follows:

$$\text{PDBN} = (\text{UR64} * \text{PP64}) + (\text{UR69} * \text{PP69}) + (\text{UR74} * \text{PP74}) + (\text{UR79} * \text{PP79}) + (\text{UR84} * \text{PP84}) + (\text{UR85+} * \text{PP85+})$$

where:

PDBN = Planning district bed need.

UR64 = The nursing home bed use rate of the population aged 0 to 64 in the planning district as determined in the most recent nursing home patient origin study authorized by the department.

PP64 = The population aged 0 to 64 projected for the planning district three years from the current year as most recently published by the Virginia Employment Commission.

UR69 = The nursing home bed use rate of the population aged 65 to 69 in the planning district as determined in the most recent nursing home patient origin study authorized by the department.

PP69 = The population aged 65 to 69 projected for the planning district three years from the current year as most recently published by the Virginia Employment Commission.

UR74 = The nursing home bed use rate of the population aged 70 to 74 in the planning district as determined in the most recent nursing home patient origin study authorized by the department.

PP74 = The population aged 70 to 74 projected for the planning district three years from the current year as most recently published by the Virginia Employment Commission.

UR79 = The nursing home bed use rate of the population aged 75 to 79 in the planning district as determined in the most recent nursing home patient origin study authorized by the department.

PP79 = The population aged 75 to 79 projected for the planning district three years from the current year as most recently published by the Virginia Employment Commission.

UR84 = The nursing home bed use rate of the population aged 80 to 84 in the planning district as determined in the most recent nursing home patient origin study authorized by the department.

PP84 = The population aged 80 to 84 projected for the planning district three years from the current year as most recently published by the Virginia Employment Commission.

UR85+ = The nursing home bed use rate of the population aged 85 and older in the planning district as determined in the most recent nursing home patient origin study authorized by the department.

PP85+ = The population aged 85 and older projected for the planning district three years from the current year as most recently published by the Virginia Employment Commission.

Planning district bed need forecasts will be rounded as follows:

| Planning District Bed Need (from above method) | Rounded Bed Need |
|---|------------------|
| 1 - 29 | 0 |
| 30 - 44 | 30 |
| 45 - 84 | 60 |
| 85 - 104 | 90 |
| 105 - 184 | 120 |
| 185+ | 240 |

except in the case of a planning district which has two or more nursing facilities, has had an average annual occupancy rate of nursing home facility beds in excess of 95% for the most recent three years for which bed utilization has been reported to the department, and has a forecasted bed need of 15 to 29

beds. In such a case, the bed need for this planning district will be rounded to 30.

D. Minimum size of new nursing home facilities. No new freestanding nursing home facilities of less than 120 beds should be authorized. Consideration will be given to the authorization of new freestanding facilities with fewer than 120 nursing home facility beds when ~~these beds~~ such facilities are ~~combined with adult care residence facilities proposed for development in a rural area and can be justified on the basis of a lack of local demand for a larger facility and a maldistribution of nursing home facility beds within the planning district.~~

E. Continuing Care Retirement Communities. Proposals for the development of new nursing home facilities or the expansion of existing facilities by Continuing Care Retirement Communities will be considered in accordance with the following standards:

1. The total number of new or additional beds plus any existing nursing home facility beds operated by the continuing care provider does not exceed 20% of the continuing care provider's total existing or planned independent living and adult care residence population;
2. The proposed beds are necessary to meet existing or reasonably anticipated obligations to provide care to present or prospective residents of the continuing care facility pursuant to continuing care contracts meeting the requirements of § 38.2-4905 of the Code of Virginia;
3. The applicant agrees in writing not to seek certification for the use of such new or additional beds by persons eligible to receive medical assistance services pursuant to Title XIX of the United States Social Security Act;
4. The applicant agrees in writing to obtain, prior to admission of every resident of the Continuing Care Retirement Community, the resident's written acknowledgement that the provider does not serve recipients of medical assistance services and that, in the event such resident becomes a medical assistance services recipient who is eligible for nursing facility placement, such resident shall not be eligible for placement in the provider's nursing facility unit;
5. The applicant agrees in writing that only continuing care contract holders who have resided in the Continuing Care Retirement Community as independent living residents or adult care residents and are holders of standard continuing care contracts will be admitted to the nursing home facility beds after the first three years of operation.

VA.R. Doc. No. R01-1; Filed May 1, 2002, 11:48 a.m.

TITLE 14. INSURANCE

STATE CORPORATION COMMISSION

REGISTRAR'S NOTICE: The State Corporation Commission is exempt from the Administrative Process Act in accordance

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with § 2.2-4002 A 2 of the Code of Virginia, which exempts courts, any agency of the Supreme Court, and any agency which by the Constitution is expressly granted any of the powers of a court of record.

Title of Regulation: 14 VAC 5-140. Rules Governing the Implementation of the Individual Accident and Sickness Insurance Minimum Standards Act (INS-2002-00060) (amending 14 VAC 5-140-20, 14 VAC 5-140-30, 14 VAC 5-140-40, 14 VAC 5-140-50, 14 VAC 5-140-60, 14 VAC 5-140-70, 14 VAC 5-140-80, and 14 VAC 5-140-90).

Statutory Authority: §§ 12.1-13 and 38.2-223 of the Code of Virginia.

Public Hearing Date: N/A--Public comments may be submitted until May 30, 2002.

Agency Contact: Althelia Battle, Principal Insurance Market Examiner, Bureau of Insurance, P.O. Box 1157, Richmond, VA 23218, telephone (804) 371-9154, FAX (804) 371-9944, toll-free 1-800-552-7945, or e-mail abattle@scc.state.va.us.

Summary:

The proposed revisions define and clarify what is necessary for coverage to be considered "limited benefit health insurance coverage" under this chapter, specifically 14 VAC 5-140-70 H. Other provisions are amended to provide consistency with revised 14 VAC 5-140-70 H. Finally, a number of nonsubstantive cleanup changes are being made.

AT RICHMOND, APRIL 29, 2002

COMMONWEALTH OF VIRGINIA

At the relation of the

STATE CORPORATION COMMISSION

CASE NO. INS-2002-00060

Ex Parte: In the matter of
Adopting Revisions to the Rules
Governing the Implementation of
the Individual Accident and
Sickness Insurance Minimum
Standards Act

ORDER TO TAKE NOTICE

WHEREAS, § 12.1-13 of the Code of Virginia provides that the Commission shall have the power to promulgate rules and regulations in the enforcement and administration of all laws within its jurisdiction, and § 38.2-223 of the Code of Virginia provides that the Commission may issue any rules and regulations necessary or appropriate for the administration and enforcement of Title 38.2 of the Code of Virginia;

WHEREAS, the rules and regulations issued by the Commission pursuant to § 38.2-223 of the Code of Virginia are set forth in Title 14 of the Virginia Administrative Code;

WHEREAS, pursuant to 5 VAC 5-20-100, an application was filed with the Commission on March 8, 2002, by Stephen D. Rosenthal, Esquire, which proposed revisions to Chapter 140 of Title 14 of the Virginia Administrative Code entitled "Rules

Governing the Implementation of the Individual Accident and Sickness Insurance Minimum Standards Act," which amend the rules at 14 VAC 5-140-20, 14 VAC 5-140-30, 14 VAC 5-140-40, 14 VAC 5-140-50, 14 VAC 5-140-60, 14 VAC 5-140-70, 14 VAC 5-140-80, and 14 VAC 5-140-90;

WHEREAS, the proposed revisions define and clarify what is necessary for coverage to be considered "limited benefit health insurance coverage";

WHEREAS, the proposed revisions also include certain nonsubstantive "clean up" changes to the aforementioned Rules;

WHEREAS, the Bureau of Insurance has no objection to the proposed revisions; and

WHEREAS, the Commission is of the opinion that the proposed revisions should be considered for adoption with a proposed effective date of July 1, 2002;

THEREFORE, IT IS ORDERED THAT:

(1) The proposed revisions to the "Rules Governing the Implementation of the Individual Accident and Sickness Insurance Minimum Standards Act," which amend the rules at 14 VAC 5-140-20, 14 VAC 5-140-30, 14 VAC 5-140-40, 14 VAC 5-140-50, 14 VAC 5-140-60, 14 VAC 5-140-70, 14 VAC 5-140-80, and 14 VAC 5-140-90 be attached hereto and made a part hereof;

(2) All interested persons who desire to comment in support of or in opposition to, or to request a hearing to oppose the adoption of, the proposed revisions shall file such comments or hearing request on or before May 30, 2002, in writing with the Clerk of the Commission, Document Control Center, P.O. Box 2118, Richmond, Virginia 23218 and shall refer to Case No. INS-2002-00060;

(3) If no written request for a hearing on the proposed revisions is filed on or before May 30, 2002, the Commission, upon consideration of any comments submitted in support of or in opposition to the proposed revisions, may adopt the revisions proposed by the Bureau of Insurance;

(4) AN ATTESTED COPY hereof, together with a copy of the proposed revisions, shall be sent by the Clerk of the Commission to Stephen D. Rosenthal, Esquire, Troutman Sanders Mays & Valentine LLP, P.O. Box 1122, Richmond, Virginia 23218-1122; and to the Bureau of Insurance in care of Deputy Commissioner Gerald A. Milsky, who forthwith shall give further notice of the proposed adoption of the revisions to the rules by mailing a copy of this Order, together with a draft of the proposed revisions, to all insurers and health services plans licensed to write accident and sickness insurance in the Commonwealth of Virginia; and by forwarding a copy of this Order, together with a draft of the proposed revisions, to the Virginia Registrar of Regulations for appropriate publication in the *Virginia Register of Regulations*; and

(5) The Bureau of Insurance shall file with the Clerk of the Commission an affidavit of compliance with the notice requirements of paragraph (4) above.

14 VAC 5-140-20. ~~Effective date, and other provisions~~ Compliance with chapter.

~~A. This chapter (14 VAC 5-140-10 et seq.) shall be effective on January 1, 1989.~~

~~B. A. No new policy form shall be approved on or after January 1, 1989, unless it complies with this chapter.~~

~~C. B. No policy form shall be delivered or issued for delivery in this State on or after January 1, 1989, Commonwealth unless it complies with this chapter.~~

14 VAC 5-140-30. Scope.

This chapter (14 VAC 5-140-10 ~~et seq.~~) shall apply to all individual accident and sickness insurance policies delivered or issued for delivery in this Commonwealth except it shall not apply to Medicare supplement, *long-term care*, and specified disease policies.

Except as otherwise provided, nothing contained in this chapter shall be construed to relieve an insurer of complying with the statutory requirements set forth in Title 38.2 of the Code of Virginia.

14 VAC 5-140-40. Policy definitions.

Except as *otherwise provided hereafter in this chapter*, no individual accident or sickness insurance policy delivered or issued for delivery to any person in this Commonwealth shall contain definitions respecting the matters set forth below unless such definitions comply with the requirements of this section.

"Accident," "accidental injury," or "accidental means" shall be defined to employ "result" language and shall not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

The definition shall not be more restrictive than the following: injury or injuries, for which benefits are provided, means accidental bodily injury sustained by the insured person which are the direct result of an accident, independent of disease or bodily infirmity or any other cause, and which occur while the insurance is in force.

Such definition may provide that injuries shall not include:

1. Injuries for which benefits are provided under any ~~workmen's~~ workers' compensation, employer's liability or similar law, motor vehicle no-fault plan, unless prohibited by law; or
2. Injuries incurred while the insured person is engaged in any activity pertaining to any trade, business, employment, or occupation for wage or profit.

"Convalescent nursing home," "extended care facility," or "skilled nursing facility" shall be defined in relation to its status, facilities, and available services.

1. A definition of such home or facility shall not be more restrictive than one requiring that it:
 - a. Be operated pursuant to law;

b. Be approved for payment of Medicare benefits or be qualified to receive such approval, if so requested;

c. Be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;

d. Provide continuous 24 hours a day nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and

e. Maintain a daily medical record of each patient.

2. The definition of such home or facility may provide that such term shall not include:

a. Any home, facility or part thereof used primarily for rest;

b. A home or facility for the aged or for the care of drug addicts or alcoholics; or

c. A home or facility primarily used for the care and treatment of mental diseases, or disorders, or custodial or educational care.

"Guaranteed renewable" as used in a renewability provision, shall not be defined more restrictively, except as provided in the definition of "non-cancellable" or "non-cancellable and guaranteed renewable," than one providing the insured the right to continue *the policy* in force by the timely payment of premiums until ~~the age of~~ 65 or until eligibility for Medicare. During this period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force, except that the insurer may make changes in premium rates by class. Class should be defined by age, sex, occupation, or other broad categories in order to eliminate any possibilities of individual discrimination. Any accident and sickness policy, however, which provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness may provide that the insured has the right to continue the policy only to age 60 if, at age ~~sixty~~ 60, the insured has the right to continue the policy in force at least to age 65 while actively and regularly employed.

"Hospital" may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals.

1. The definition of the term "hospital" shall not be more restrictive than one requiring that the hospital:

a. Be an institution operated pursuant to law;

b. Be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of duly licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made; and

c. Provide 24 hours *a day* nursing service by or under the supervision of a registered graduate professional ~~nurses~~ nurse (R.N.'s R.N.).

2. The definition of the term "hospital" may state that such term shall not include:

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- a. Convalescent homes, convalescent, rest, nursing facilities;
- b. Facilities primarily affording custodial, educational or rehabilitatory care;
- c. Facilities for the aged, drug addicts or alcoholics subject to the requirements of ~~§ 38.2-3412~~ 38.2-3412.1 of the Code of Virginia; or
- d. Any military or veterans hospital or soldiers home or any hospital contracted for or operated by any national government or agency thereof, except as provided in 14 VAC 5-140-60 E, for the treatment of members or ex-members of the armed forces, except for services rendered on an emergency basis where a legal liability exists for charges made to the individual for such services.

"Medical necessity," or words of similar meaning, shall not be defined more restrictively than all services rendered to an insured that are required by his medical condition in accordance with generally accepted principles of good medical practice, which are performed in the least costly setting and not only for the convenience of the patient or his physician.

"Medicare" shall be defined in any hospital, surgical or medical expense policy which relates its coverage to eligibility for Medicare or Medicare benefits. Medicare may be substantially defined as "the 'Health Insurance for the Aged Act,' Title XVIII of the Social Security Amendments of 1965 (42 USC § 1395 et seq.) or 'Title I, Part 1 of the Public Laws 89-97, as enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the 'Health Insurance for the Aged Act,' (42 USC § 1395 et seq.), or words of similar import.

"Mental or nervous disorders" shall not be defined more restrictively than a definition including neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind including physiological and psychological dependence on alcohol and drugs subject to ~~§ 38.2-3412~~ 38.2-3412.1 of the Code of Virginia.

"Non-cancellable," or "non-cancellable and guaranteed renewable," as used in a renewability provision, shall not be defined more restrictively than one providing the insured the right to continue the policy in force by the timely payment of premiums set forth in the policy until the age of 65 or until eligibility for Medicare. During this period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force. Any accident and sickness policy, however, which provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness may provide that the insured has the right to continue the policy only to age 60, if at age 60, the insured has the right to continue the policy in force at least to age 65 while actively ~~or~~ and regularly employed.

"Nurses Nurse" may be defined so that the description of nurse is restricted to a type of nurse, such as registered graduate professional nurse (R.N.), a licensed practical nurse

(L.P.N.), or a licensed vocational nurse (L.V.N.). If the words "nurse," "trained nurse" or "registered nurse" are used without specific description as to type, then the use of such terms requires the insurer to recognize the services of any individual who qualifies under such terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of this Commonwealth.

"One period of confinement" means consecutive days of in-hospital service received as an inpatient, or successive confinements when discharge from and readmission to the hospital occurs within a period of not more than 90 days or three times the maximum number of days of in-hospital coverage provided by the policy to a maximum of 180 days.

"Partial disability" shall be defined in relation to the individual's inability to perform one or more but not all of the "major," "important," or "essential" duties of employment or occupation or may be related to a "percentage" of time worked or to a "specified number of hours" or to "compensation." Where a policy provides total disability benefits and partial disability benefits, only one elimination period may be required.

"Physician" may be defined by including words such as "duly qualified physician" or "duly licensed physician."

"Preexisting condition," except as defined in §§ 38.2-3432.3 and 38.2-3514.1 of the Code of Virginia, shall not be defined to be more restrictive than the following:

1. The existence of symptoms ~~which~~ that would cause an ordinarily prudent person to seek diagnosis, care or treatment within a two(2)-year period preceding the effective date of the coverage of the insured person; or
2. A condition for which medical advice or treatment was recommended by a physician or received from a physician within a two(2)-year period preceding the effective date of the coverage of the insured person.

"Residual disability" shall be defined in relation to the individual's reduction in earnings and may be related either to the inability to perform some part of the "major," "important," or "essential" duties of employment or occupation, or to the inability to perform all usual business duties for as long as is usually required. A policy which provides for residual disability benefits may require a qualification period, during which the insured must be continuously, and totally disabled before residual disability benefits are payable. The qualification period for residual benefits may be longer than the elimination period for total disability. In lieu of the term "residual disability," the insurer may use "proportionate disability" or other term of similar import ~~which~~ that in the opinion of the commission adequately and fairly describes the benefit.

"Sickness" shall not be defined to be more restrictive than the following:

Sickness means sickness or disease of an insured person, which manifests itself after the effective date of insurance and while the insurance is in force. A definition of sickness may provide for a probationary period, which ~~will~~ shall not exceed 30 days from the effective date of the coverage of the insured person. The definition may be further modified to exclude sickness or disease for which benefits are

provided under any ~~workmen's~~ workers' compensation, occupational disease, employer's liability or similar law.

"Total disability" means:

1. A general description of total disability ~~cannot~~ *shall not* be more restrictive than one requiring the individual to be totally disabled from engaging in an employment or occupation for which he is or becomes qualified by reason of education, training or experience and not in fact engaged in any employment or occupation for wage or profit.

2. Total disability may be defined in relation to the inability of the person to perform duties but may not be based solely upon an individual's inability to: (i) perform "any occupation whatsoever," "any occupational duty," or "any and every duty of his occupation"; or (ii) ~~engaged~~ *engage* in any training or rehabilitation program.

3. An insurer may specify the requirement of the complete inability of the person to perform all of the substantial and material duties of his regular occupation or words of similar import. An insurer may require care by a physician (other than the insured or a member of the insured's immediate family).

14 VAC 5-140-50. General policy requirements.

A. A "non-cancellable," "guaranteed renewable," or "non-cancellable and guaranteed renewable" policy shall not provide for termination of coverage of the spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than nonpayment of premium. The policy shall provide that in the event of the insured's death, the spouse of the insured, if covered under the policy, shall become the insured.

B. The renewability provisions *designated* "non-cancellable," "guaranteed renewable" or "non-cancellable and guaranteed renewable" shall not be used without further explanatory language in accordance with the disclosure requirements of 14 VAC 5-140-80 A 1.

C. In a family policy covering both husband and wife, the age of the younger spouse ~~must~~ *shall* be used as the basis for meeting the age and ~~durational~~ *duration* requirements of the definitions of "non-cancellable" or "guaranteed renewable." This requirement, however, shall not prevent termination of coverage of the older spouse upon attainment of the stated age limit (e.g., age 65) so long as the policy may be continued in force as to the younger spouse, to the age or for the ~~durational period as~~ *duration* specified in ~~said~~ *the* definition.

D. When accidental death and dismemberment coverage is part of the insurance coverage offered under the contract, the insured shall have the option to include all insureds under such coverage and not just the principal insured.

E. If a policy contains a status type military service exclusion or a provision which suspends coverage during military service, the policy shall provide, upon receipt of written notice of military service, for refund of premiums as applicable to such person on a pro rata basis.

F. In the event the insurer cancels or refuses to renew coverage, policies providing pregnancy benefits shall provide

for an extension of benefits as to pregnancy commencing while the policy is in force and for which benefits would have been payable had the policy remained in force.

G. Policies providing convalescent or extended care benefits following hospitalization shall not condition such benefits upon admission to the convalescent or extended care facility within a period of less than 14 days after discharge from the hospital.

H. Any policy providing coverage for the recipient in a transplant operation shall also provide reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy, after benefits for the recipient's own expenses have been paid.

I. A policy may contain a provision relating to recurrent disabilities; provided, however, that no such provision shall specify that a recurrent disability be separated by a period greater than six months.

J. Accidental death and dismemberment benefits shall be payable if the loss occurs within 90 days from the date of the accident, irrespective of total disability, or occurs within one year from the date of the accident and during a period of continuous total disability resulting from the accident and commencing within 30 days of the date of the accident. Disability income benefits, if provided, shall not require the loss to commence less than 30 days after the date of *the* accident, nor shall any policy which the insurer cancels or refuses to renew require that it be in force at the time disability commences if the accident occurred while the policy was in force.

K. Specific dismemberment benefits shall not be in lieu of other benefits unless the specific benefit equals or exceeds the other benefits.

L. Termination of the policy shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits.

14 VAC 5-140-60. Prohibited policy provisions.

A. Except as provided in the definition of sickness *in* {14 VAC 5-140-40}, no policy shall contain provisions establishing a probationary or waiting period during which no coverage is provided under the policy subject to the further exception that a policy may specify a probationary or waiting period not to exceed six months for specified diseases or conditions and losses resulting therefrom for hernia, disorder of reproduction organs, varicose veins, adenoids, appendix and tonsils. However, the permissible six months exception shall not be applicable where such specified diseases or conditions are treated on an emergency basis. Accident policies shall not contain probationary or waiting periods.

B. No policy or rider for additional coverage may be issued as a dividend unless an equivalent cash payment is offered to the policyholder as an alternative to such dividend policy or rider. No such dividend policy or rider shall be issued for an initial term of less than six months.

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The initial renewal subsequent to the issuance of any policy or rider as a dividend shall clearly disclose that the policyholder is renewing the coverage that was provided as a dividend for the previous term and that such renewal is optional with the policyholder.

C. No policy shall exclude coverage for a loss due to a preexisting condition for a period greater than 12 months following policy issue where the application for such insurance does not seek disclosure of prior illness, disease or physical conditions or prior medical care and treatment and such preexisting condition is not specifically excluded by the terms of the policy.

D. A disability income protection policy may contain a "return of premium" or "cash value benefit" so long as:

1. Such return of premium or cash value benefit is not reduced by an amount greater than the aggregate of any claims paid under the policy; and
2. The insurer demonstrates that the reserve basis for ~~such policies~~ *the policy* is adequate.

No other policy shall provide a return of premium or cash value benefit, except return of unearned premium upon termination or suspension of coverage, retroactive waiver of premium paid during disability, payment of dividends on participating policies, or experience rating refunds.

E. Policies providing hospital confinement indemnity coverage shall not contain provisions excluding coverage because of confinement in a hospital operated by the federal government.

F. No policy shall limit or exclude coverage by type of illness, accident, treatment or medical condition, except as follows:

1. Preexisting conditions or diseases, except for congenital anomalies of a covered dependent child;
2. Mental or emotional disorders, alcoholism and drug addiction, subject to § ~~38.2-3442~~ 38.2-3412.1 of the Code of Virginia;
3. Pregnancy, except for complications of pregnancy, other than for policies defined in 14 VAC 5-140-70 F and G;
4. Illness, treatment or medical condition arising out of:
 - a. War or act of war (whether declared or undeclared); participation in a felony, riot or insurrections; service in the armed forces or *auxiliary* units ~~auxiliary thereto~~;
 - b. Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury;
 - c. Aviation;
 - d. With respect to short-term nonrenewable policies, interscholastic sports;
5. Cosmetic surgery, except that "cosmetic surgery" shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect;

6. Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet;

7. Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of, or in the vertebral column;

8. Treatment provided in a government hospital; benefits provided under Medicare or other governmental program (except Medicaid), any state or federal ~~workmen's~~ *workers'* compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law; services rendered by employees of hospitals, laboratories or other institutions; services performed by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance;

9. Dental care or treatment;

10. Eyeglasses, hearing aids and examination for the prescription or fitting thereof;

11. Rest cures, custodial care, transportation and routine physical examinations;

12. Territorial limitations;

13. Services or care not medically necessary-;

14. Limited benefit health insurance coverage as approved by the commission and in accordance with 14 VAC 5-140-70 H (i).

G. Other provisions of this chapter shall not impair or limit the use of waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases, physical condition or extra hazardous activity. Where waivers are required as a condition of issuance, renewal or reinstatement, signed acceptance by the insured is required unless on initial issuance the full text of the waiver is contained either on the first page or specification page of the policy or unless notice of the waiver appears on the first page or specification page *of the policy*.

H. Policy provisions precluded in this section shall not be construed as a limitation on the authority of the commission to disapprove other policy provisions in accordance with § 38.2-3518 *of the Code of Virginia* ~~which that~~, in the opinion of the commission, are unjust, unfair, or unfairly discriminatory to the policyholder, beneficiary, or any person insured under the policy.

I. Except as provided in provisions pertaining to "preexisting conditions" in 14 VAC 5-140-40 F, no policy shall exclude coverage for an illness or sickness ~~which that~~ manifests itself ~~(makes itself known)~~ prior to the effective date of the policy.

14 VAC 5-140-70. Accident and sickness minimum standards for benefits.

A. The following minimum standards for benefits are prescribed for the categories of coverage noted in ~~the following~~ subsections *B through G of this section*. No

individual policy of accident and sickness insurance shall be delivered or issued for delivery in this Commonwealth which does not meet the required minimum standards for the specified categories unless the commission finds that ~~such policies the policy or contracts are~~ *contract is* approvable as limited benefit health insurance.

Nothing in this section shall preclude the issuance of any policy or contract combining two or more categories of coverage set forth in §§ 38.2-3519 A and 38.2-3519 B of the *Code of Virginia*.

B. Basic hospital expense coverage. "Basic hospital expense coverage" is a policy of accident and sickness insurance which provides coverage for a period of not less than 31 days during any continuous hospital confinement for each person insured under the policy, for expenses incurred for the necessary treatment and services rendered as a result of accident or sickness for at least the following:

1. Daily hospital room and board in an amount not less than the lesser of: (i) 80% of the charges for semi-private room accommodations; or (ii) \$60 per day;
2. Miscellaneous hospital services for expenses incurred for the charges made by the hospital for services and supplies which are customarily rendered by the hospital and provided for use only during any one period of confinement in an amount not less than either: (i) 80% of the charges incurred up to at least \$2,000; or (ii) 10 times the daily hospital room and board benefits; and
3. Hospital outpatient services consisting of: (i) hospital services on the day surgery is performed; (ii) hospital services rendered within 72 hours after accidental injury, in an amount not less than \$100; and (iii) X-ray and laboratory tests to the extent that benefits for such services would have been provided to an extent not less than \$200 if rendered to an inpatient of the hospital.
4. Benefits provided under *subdivisions 1 and 2 or B above, of this subsection* may be provided subject to a combined deductible amount not in excess of \$200.

C. Basic Medical-Surgical Expense Coverage. "Basic medical-surgical expense coverage" is a policy of accident and sickness insurance which provides coverage for each person insured under the policy for the expenses incurred for the necessary services rendered by a physician for treatment of an injury or sickness for at least the following:

1. Surgical services:
 - a. In amounts not less than those provided on a fee schedule based on the relative values contained in the State of New York certified surgical fee schedule, or the 1964 California Relative Value Schedule or other acceptable relative value scale of surgical procedures, up to a maximum of at least \$1,000 for any one procedure; or
 - b. Not less than 80% of the reasonable charges.
2. Anesthesia services, consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical service rendered by a

physician other than the physician (or his assistant) performing the surgical ~~services~~ *service*:

- a. In an amount not less than 80% of the reasonable charges; or
- b. 15% of the surgical service benefit.

3. In-hospital medical services, consisting of physician services rendered to a person who is a bed patient in a hospital for treatment of sickness or injury other than that for which surgical care is required, in an amount not less than: (i) 80% of the reasonable charges; or (ii) \$10 per day for not less than 31 days during the period of confinement.

D. Hospital confinement indemnity coverage. "Hospital confinement indemnity coverage" is a policy of accident and sickness insurance which provides daily benefits for hospital confinement on an indemnity basis in an amount not less than \$30 per day and not less than 31 days during any one period of confinement for each person insured under the policy.

E. Major medical expense coverage. "Major medical expense coverage" is an accident and sickness insurance policy which provides hospital, medical, and surgical expense coverage, to an aggregate maximum of not less than \$25,000; copayment by the covered person not to exceed 25% of covered charges; a deductible stated on a per person, per family, per illness, per benefit period, or per year basis, or a combination of such bases not to exceed 5% of the aggregate maximum limit under the policy, unless the policy is written to complement underlying hospital and medical insurance, in which case such deductible may be increased by the amount of the benefits provided by such underlying insurance, for each covered person for at least:

1. Daily hospital room and board expenses, prior to application of the copayment percentage, for not less than \$100 daily (or in lieu thereof the average daily cost of *the* semi-private room rate in the area where the insured resides) for a period of not less than 60 days during continuous hospital confinement;
2. Miscellaneous hospital services, prior to application of the copayment percentage, for an aggregate maximum of not less than \$3,000 or 15 times the daily room and board rate if specified in dollar amounts;
3. Surgical services, prior to application of *the* copayment percentage to a maximum of not less than \$1,200 for the most severe operation with the amounts provided for other operations reasonably related to such maximum amount;
4. Anesthesia services, prior to application of the copayment percentage, for a maximum of not less than 15% of the covered surgical fees or, alternatively, if the surgical schedule is based on relative values, not less than the amount provided therein for anesthesia services at the same unit value as used for the surgical schedule;
5. In-hospital medical services, prior to application of the copayment percentage, consisting of physician services rendered to a person who is a bed patient in a hospital for treatment of sickness or injury other than that *for* which surgical care is required;

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6. Out-of-hospital care, prior to application of the copayment percentage, consisting of physicians' services rendered on an ambulatory basis where coverage is not provided elsewhere in the policy for diagnosis and treatment of sickness or injury, and diagnostic x-ray, laboratory services, radiation therapy, and hemodialysis ordered by a physician; and

7. Not fewer than three of the following additional benefits, prior to application of the copayment percentage, or an aggregate maximum of such covered charges of not less than \$2,000:

- a. In-hospital private duty ~~graduate~~ registered *graduate professional* nurse services.
- b. Convalescent nursing home care.
- c. Diagnosis and treatment by a radiologist or physiotherapist.
- d. Rental of special medical equipment, as defined by the insurer in the policy.
- e. Artificial limbs or eyes, casts, splints, trusses or braces.
- f. Out-of-hospital prescription drugs and medications.
- g. Treatment for functional nervous disorders, and mental and emotional disorders unless required by § ~~38.2-3412~~ 38.2-3412.1 of the Code of Virginia.

F. Disability income protection coverage. "Disability income protection coverage" is a policy which provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from either sickness or injury or a combination thereof which:

- 1. Provides that periodic payments, which are payable ~~at~~ ~~ages~~ after age 62 and reduced solely on the basis of age, are at least 50% of amounts payable immediately prior to age 62.
- 2. Contains an elimination period no greater than:
 - a. 90 days in the case of a coverage providing a benefit of one year or less;
 - b. 180 days in the case of coverage providing a benefit of more than one year but not greater than two years; or
 - c. 365 days in all other cases during the continuance of disability resulting from sickness or injury.
- 3. Has a maximum period of time for which ~~it~~ *a benefit* is payable during disability of at least six months except in the case of a policy covering disability arising out of pregnancy, childbirth, or miscarriage in which case the period for such disability may be *limited to* one month. No reduction in benefits shall be put into effect because of an increase in social security or similar benefits during a benefit period.

This section does not apply to those policies providing business buy-out coverage.

G. Income replacement coverage. "Income replacement coverage" is a policy which provides for periodic payments, weekly or monthly, for a specified period during which there is

a loss of income resulting from sickness, injury, or a combination thereof which:

- 1. Provides that periodic payments, which are payable ~~at~~ ~~ages~~ after age 62 and reduced solely on the basis of age, are at least 50% of amounts payable immediately prior to age 62.
- 2. Contains an elimination period no greater than:
 - a. 90 days in the case of a coverage providing a benefit of one year or less;
 - b. 180 days in the case of coverage providing a benefit of more than one year but not greater than two years; or
 - c. 365 days in all other cases during the continuance of loss of income resulting from sickness or injury;
- 3. Has a maximum period of time for which ~~it~~ *a benefit* is payable during the continuance of loss of income of at least six months except in the case of a policy covering loss of income arising out of pregnancy, childbirth, or miscarriage in which case the maximum period may be limited to one month. No reduction in benefits shall be put into effect because of an increase in social security or similar benefits during a benefit period;
- 4. Requires loss of income to be no greater than 80% of *predisability income* in order to pay full periodic benefits; and
- 5. The front page of the policy shall contain the following statements: THIS IS AN INCOME REPLACEMENT POLICY. THE POLICY PAYS NO BENEFITS IF THERE IS NO LOSS OF INCOME. (This notice must be in capital letters and in no less than 14-point type.)

This section does not apply to those policies providing business buy-out coverage.

H. Limited benefit health insurance coverage. "Limited benefit health insurance coverage" is any policy or contract ~~which that: (i) provides less coverage than the standards for benefits required under for a category or categories not specified in subsections B through G of this section; or is any policy that, or in any other chapter in Title 14 of the Virginia Administrative Code; (ii) provides coverage for a category or categories specified in subsections B through G of this section, but does not meet the minimum standards for the specified category or categories; or (iii) provides accident only coverage or specified accident only coverage. These policies, if shall be approved by the commission, and upon approval, may be delivered or issued for delivery in this Commonwealth only as limited benefit health insurance and not as basic health expense or indemnity insurance or any other type of coverage defined in this section. These policies must shall meet the disclosure requirements set forth in 14 VAC 5-140-80.~~

14 VAC 5-140-80. Required disclosure provisions.

A. General rules for all policies.

- 1. Each individual policy of accident or sickness insurance shall include a renewal, continuation or nonrenewal provision. The language or specifications of such provision ~~must~~ *shall* be consistent with the type of contract to be

issued. Such provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.

2. Except for riders or endorsements by which the insurer fulfills a request made in writing by the policyholder or exercises a specifically reserved right under the policy, all riders or endorsements added to a policy after *the* date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the policyholder. After *the* date of policy issue, any rider or endorsement which increases benefits or coverage with an accompanying increase in premium during the policy term ~~must~~ *shall* be agreed to in writing signed by the insured, except if the increased benefits or coverage is required by law.

3. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy.

4. A policy which provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import shall include an explanation of such terms.

5. If a policy contains any limitations with respect to preexisting conditions such limitations must appear as a separate paragraph of the policy and be labeled as "Preexisting ~~Condition Limitations~~ *Conditions Limitation*."

6. If age is to be used as a determining factor for reducing the maximum aggregate benefits made available in the policy as originally issued, such fact must be prominently set forth in the policy.

7. If a policy contains a conversion privilege, it shall comply, in substance, with the following:

a. The caption of the provision shall be "Conversion Privilege," or words of similar import;

b. The provision shall indicate the persons eligible for conversion, the circumstances applicable to the conversion privilege, including any limitations on the conversion, and the person by whom the conversion privilege may be exercised;

c. The provision shall specify the benefits to be provided on conversion or may state that the converted coverage ~~will~~ *shall* be as provided on a policy form then being used by the insurer for that purpose.

B. Rules for limited benefit policies, other than accident only or specified accident only policies. The following disclosure requirements ~~must~~ *shall* be met by all limited benefit policies:

1. A cover sheet, containing only the following information shall be permanently attached to the front of the policy:

COMPANY NAME

LOGO (OPTIONAL)

NOTICE: LIMITED BENEFIT DISCLOSURE FORM. THE POLICY DESCRIBED IN THIS COVER SHEET DOES NOT MEET THE MINIMUM STANDARDS REQUIRED BY THE BUREAU OF INSURANCE, VIRGINIA STATE CORPORATION COMMISSION, FOR INDIVIDUAL ACCIDENT AND SICKNESS POLICIES. (This notice must be in capital letters and in no less than 14-point type.)

Minimum standards were established by the Bureau to insure the availability of health insurance contracts providing a minimum of basic benefits needed for health care. This policy does not meet the Virginia minimum standards for the following reason(s): (A listing of the reason(s) ~~will~~ *shall* be furnished by the Bureau at the time the contract is reviewed and the actual Bureau language ~~must~~ *shall* be used.)

(The following language ~~is~~ *shall* be required for an insurer, other than a direct response insurer.) I have read this cover sheet and realize that this policy does not meet minimum standards required by Virginia law and that it can only be sold as a LIMITED BENEFIT POLICY.

Signature

FORM NUMBER

This is a disclosure form. It is not part of the policy to which it is attached.

2. The cover sheet shall contain one duplicate copy to be maintained by the insurance company for the length of time that the policy is in force or for three years, whichever is greater.

C. Rules for accident and specified accident only policies. The following disclosure requirement ~~must~~ *shall* be met by all accident only and specified accident only policies:

Insurers have the option of (i) printing, clearly stamping or printing on gum labels on the first page of the policy, (ii) attaching a cover sheet to the front of the policy or (iii) adding to their outline of coverage, which ~~must~~ *shall* be attached to the front of the policy, the following information:

NOTICE: THIS IS A LIMITED BENEFIT POLICY. IT DOES NOT PAY ANY BENEFITS FOR LOSS FROM SICKNESS. THIS POLICY PROVIDES RESTRICTIVE COVERAGE FOR CERTAIN LOSSES WHICH OCCUR AS A RESULT OF (AN ACCIDENT) (A SPECIFIED ACCIDENT) ONLY. (This notice ~~must~~ *shall* be in capital letters and in no less than 14-point type.)

14 VAC 5-140-90. Requirements for replacement.

A. Application forms shall include a question designed to elicit information as to whether the insurance to be issued is intended to replace any other accident and sickness insurance presently in force.

B. Upon determining that a sale will involve replacement, an insurer, other than a direct response insurer, or its agent shall furnish the applicant, prior to issuance or delivery of the policy, the notice described in subsection C ~~below~~ *of this section*. One copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. A direct response insurer shall deliver to the applicant upon issuance of the policy, the notice described in

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subsection D ~~below~~ of this section. In no event, however, ~~will~~ *shall* such a notice be required in the solicitation of the following types of policies: accident only and single premium nonrenewable policies.

C. The notice required by subsection B ~~above~~ of this section for an insurer, other than a direct response insurer, shall provide, in substantially the following form:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by (insert Company Name) Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. You may wish to secure the advice of your present insurer or its agency regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

(Date)

(Applicant's Signature)

D. The notice required by subsection B ~~above~~ of this section for a direct response insurer shall be as follows:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with the policy delivered herewith issued by (insert Company Name) Insurance Company. Your new policy provides 10 days within which you may decide without cost whether you desire to keep the policy. For your own information and protection you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

3. (To be included only if the application is attached to the policy.) If, after due consideration you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to (insert Company Name and Address) within 10 days if any information is not correct and complete, or if any medical history has been left out of the application.

(Company Name)

VA.R. Doc. No. R02-174; Filed April 30, 2002, 3:02 p.m.

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

BOARD OF PHYSICAL THERAPY

Title of Regulation: **18 VAC 112-20. Regulations Governing the Practice of Physical Therapy (amending 18 VAC 112-20-10, 18 VAC 112-20-130, 18 VAC 112-20-135, and 18 VAC 112-20-140; adding 18 VAC 112-20-131 and 18 VAC 112-20-136).**

Statutory Authority: §§ 54.1-2400, 54.1-3474 and 54.1-3480.1 of the Code of Virginia.

Public Hearing Date: July 12, 2002 - 9 a.m.

Public comments may be submitted until July 19, 2002.

(See Calendar of Events section for additional information)

Agency Contact: Elaine J. Yeatts, Agency Regulatory Coordinator, Department of Health Professions, 6606 W. Broad Street, 4th Floor, Richmond, VA 23230, telephone (804) 662-9918, FAX (804) 662-9114, or e-mail elaine.yeatts@dhp.state.va.us.

Basis: Section 54.1-2400 of the Code of Virginia establishes the general powers and duties of health regulatory boards including the responsibility to promulgate regulations, levy fees, administer a licensure and renewal program, and discipline regulated professionals.

Section 54.1-3474 of the Code of Virginia mandates the board to promulgate regulations establishing requirements to ensure continuing competency of physical therapists and physical therapist assistants, which may include continuing education, testing, or such other requirements as the board may determine to be necessary.

Section 54.1-3480.1 of the Code of Virginia requires the board to prescribe criteria for approval of courses of study and credit hour requirements.

Purpose: Chapters 858 and 315 of the 2001 Acts of the Assembly amended the physical therapy practice act by mandating that the board promulgate regulations for the establishment of continuing competency requirements. To carry out that mandate, the board established an advisory committee to study the type and amount of continuing education to be required, review what other states require, and develop a recommendation for the adoption of emergency regulation.

In promulgating regulations for continued competency of physical therapy licensees, the board considered the mandate of the General Assembly to adopt regulations that would address (i) the need to promote ethical practice, (ii) an appropriate standard of care, (iii) patient safety, (iv) application of new medical technology, (v) appropriate communication with patients, and (vi) knowledge of the changing health care system.

The goal of the board was to develop requirements that would: (i) encourage learner-directed continuing education through which a practitioner can identify a practice question or problem, seek the learning activity which provides needed information or teaches a new skill, and thereby, enhance his expertise or ability to practice; (ii) offer a choice of content and form that is flexible enough to meet the needs of physical therapists and physical therapist assistants in a variety of practice settings in any location in Virginia; and (iii) assure the public that therapists have maintained their skills and competencies in order to protect the public health, safety and welfare.

Substance: The Ad Hoc Advisory Committee recommended and the board adopted amendments that require a total of 30 contact hours per biennium as follows: (i) physical therapists must have at least 15 hours and physical therapist assistants at least 10 hours of Type 1, face-to-face continuing education, which must be offered by an approved sponsor or organization that provides documentation of hours to the practitioner. The hours may include formal course work, in-service training, or other educational experience and (ii) no more than 15 hours required for physical therapists and no more than 20 hours required for physical therapist assistants may be in Type 2 continuing learning activities, which may or may not be approved by a sponsor or organization but shall be activities considered by the learner to be beneficial to practice or to continuing learning; therapists document their own participation on forms provided by the board.

There are also rules for maintaining documentation of continuing education, auditing, extensions and exemptions. Evidence of continuing competency hours would be required

for reinstatement of a lapsed license or reactivation of an inactive license.

Issues:

Advantages to the licensees. The continuing competency requirements are intended to provide some assurance to the public that licensees of the board are maintaining current knowledge and skills, while providing the maximum amount of flexibility and availability to licensees. The board believes that the majority of PTs and PTAs already obtain sufficient hours of continuing competency activities or courses in a biennium. Physical therapists who work for organizations are often required to take in-service training or continuing education for employment. Only 15 of the hours for PTs and only 10 of the hours for PTAs must be offered by a recognized sponsor, the other hours may be acquired by the practitioner on his own time and schedule. The resources for earning the hours and engaging in the required learning are numerous and readily available in all parts of Virginia.

Disadvantages to the licensees. For a small minority of practitioners who do not currently engage in any continuing learning in their profession, these requirements will represent an additional burden. However, it was determined by enactment of the statute and by the board's concurrence that those practitioners and their patients would greatly benefit from continuing learning requirements, and that the public is better protected if there is some assurance of that effort.

Advantages or disadvantages to the public. There are definite advantages of the proposed amended regulations to the public, who will have greater assurance that the licensees for the board are engaged in activities to maintain and improve their knowledge and skills in providing care to their patients. The public is also better served by a continuing competency requirement for licensees who have allowed their license to lapse or have been inactive.

Advantages or disadvantages to governmental agencies. Government agencies that employ physical therapists may incur additional costs if they elect to hire individuals to present workshops or seminars to their staff or to pay for continuing education. The board will incur additional costs to monitor compliance of licensees and to hold additional disciplinary hearings for individuals who do not comply with the requirement.

Department of Planning and Budget's Economic Impact Analysis: The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007 G of the Administrative Process Act and Executive Order Number 25 (98). Section 2.2-4007 G requires that such economic impact analyses include, but need not be limited to, the projected number of businesses or other entities to whom the regulation would apply, the identity of any localities and types of businesses or other entities particularly affected, the projected number of persons and employment positions to be affected, the projected costs to affected businesses or entities to implement or comply with the regulation, and the impact on the use and value of private property. The analysis presented below represents DPB's best estimate of these economic impacts.

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Summary of the proposed regulation. Sections 54.1-3474 and 54.1-3480.1 of the Code of Virginia mandate that the Board of Physical Therapy establish continuing education requirements for practitioners whom it licenses. The proposed regulations are identical to and will replace emergency regulations that went into effect on November 1, 2001. The proposed regulations require 30 hours of continuing education per biennium for the renewal of an active license. Physical therapists must have at least 15 hours, physical therapist assistants at least 10 hours of Type 1, face-to-face continuing education that must be offered by an approved sponsor or organization. The remaining hours may be gained by consultation, self-study or other activities considered by the learner as valuable to continued learning in his practice.

The regulations also address the retention of records, random audits, extensions and exemptions, and continuing education requirements for the reactivation of an inactive or lapsed license.

Estimated economic impact. The most significant change proposed to the current regulations is the addition of continuing education (CE) requirements for the renewal of an active license. The existing rules do not require any proof of continuing competency in the profession. The monetary costs of this provision are the costs of any courses offered for the purposes of meeting the requirements of this regulation (whether paid for by the practitioner, his employer, or professional association).

Compliance costs for meeting the CE requirements will differ across licensees. Some licensees may already be obtaining CE hours during employer in-service training sessions or for professional credentialing. For these individuals, the proposed requirements will not result in any additional costs aside from those associated with the documentation and maintenance of records. For other practitioners, however, the proposed CE requirements can be expected to represent a new cost. Based on information provided by the agency, the monetary costs for earning the required CE hours could range from \$0 to several hundred dollars per biennium for each of the 5,600 licensees.¹ Additionally, practitioners would incur the cost of the time spent on pursuing such activities, whether in lost income or lost leisure time, and any costs associated with the documentation and maintenance of the records.

Reinstatement of Inactive and Lapsed Licenses

Requirements are set forth that the reactivation of an inactive license or reinstatement of a lapsed license include documentation of having completed continued competency hours equal to the requirement for the length of time, not to exceed four years, that the license has been inactive. In addition, practitioners who have not engaged in active practice (at least 320 hours of professional practice within the previous 48 months) must serve a board-approved practice under the supervision of a licensed physical therapist.

Conclusion

¹ Opportunities for continuing education hours include courses offered during the Virginia Physical Therapy Association (VPTA) annual conference (\$300 for 15 to 18 hours CE) and courses offered by medical facilities (e.g. the regional medical center in the Harrisonburg area offers 11.5 hour courses for \$200).

The proposed CE requirements and license reactivation criteria can be expected to provide some beneficial results. The proposed rules would provide some assurance to the public that licensees of the Board of Physical Therapy are maintaining their knowledge, skills, and competencies. While there is no empirical evidence currently available with which to estimate the potential benefits resulting from the proposed requirements, even just a few instances of serious injury avoided due to additional safeguards to assure the competency of practitioners would justify the anticipated costs of this regulation.

The Board of Physical Therapy will also incur costs related to enforcement of the proposed CE requirements. Based on experience with other professions, the board estimates that the biennial audits of licensees will result in approximately 20 cases settled with a pre-hearing consent order (\$100 per case) and 3 cases requiring informal conference committee proceedings (\$500 per case). Enforcement of the proposed requirements will increase compliance, and if the requirements themselves result in a net economic benefit, then the enforcement costs are also justified.

Businesses and entities affected. There are 4,136 physical therapists and 1,503 physical therapist assistants currently licensed in Virginia who would be affected by the proposed changes to this regulation.

Localities particularly affected. The proposed changes to this regulation are not expected to uniquely affect any particular localities.

Projected impact on employment. The proposed changes to this regulation are not expected to have any significant impact on employment in Virginia.

Effects on the use and value of private property. The proposed changes to this regulation are not expected to have any significant effects on the use and value of private property in Virginia.

Agency's Response to the Department of Planning and Budget's Economic Impact Analysis: The Board of Physical Therapy concurs with the analysis of the Department of Planning and Budget for 18 VAC 112-20.

Summary:

The proposed amendments require 30 contact hours of continuing education, within the two years immediately preceding renewal. Physical therapists must have at least 15 hours and physical therapist assistants at least 10 hours of Type 1, face-to-face continuing education, which must be offered by an approved sponsor or organization. The remaining required hours may be in self-learning (Type 2) activities that are considered by the therapist or therapist assistant to be beneficial to practice or to continued learning. Proposed amendments also provide for documenting continuing education hours, retention of records, random audits, extensions and exemptions, and continuing education requirements for the reactivation of an inactive or lapsed license.

18 VAC 112-20-10. Definitions.

The following words and terms when used in this chapter shall have the following meanings, unless the context clearly indicates otherwise:

"Approved program" means an educational program accredited by the Commission on Accreditation in Physical Therapy Education of the American Physical Therapy Association.

"Board" means the Virginia Board of Physical Therapy.

"CLEP" means the College Level Examination Program.

"Contact hour" means 60 minutes of time spent in continuing learning activity exclusive of breaks, meals or vendor exhibits.

"Direct supervision" means a physical therapist is present and is fully responsible for the activities performed by the nonlicensed physical therapy personnel.

"Evaluation" means the carrying out by a physical therapist of the sequential process of assessing a patient, planning the patient's physical therapy treatment program, and recording appropriate documentation.

"Face-to-face" means learning activities or courses obtained in a group setting or through interactive, real-time technology.

"FCCPT" means the Foreign Credentialing Commission on Physical Therapy.

"General supervision" means a physical therapist shall be available for consultation.

"Nonlicensed personnel" means any individual not licensed or certified by a health regulatory board within the Department of Health Professions who is performing patient care functions at the direction of a physical therapist or physical therapist assistant within the scope of this chapter.

"Physical therapist" means a person qualified by education and training to administer a physical therapy program.

"Physical therapist assistant" means a person qualified by education and training to perform physical therapy functions under the supervision of and as directed by a physical therapist.

"TOEFL" means the Test of English as a Foreign Language.

"Trainee" means a person undergoing a traineeship.

1. *"Foreign educated trainee"* means a physical therapist or physical therapist assistant who graduated from a school not approved by an accrediting agency recognized by the board and who is seeking licensure to practice in Virginia.

2. *"Inactive practice trainee"* means a physical therapist or physical therapist assistant who has previously been licensed and has not practiced for at least 320 hours within the past four years and who is seeking licensure or relicensure in Virginia.

3. *"Unlicensed graduate trainee"* means a graduate of an approved physical therapist or physical therapist assistant program who has not taken the state licensure examination

or who has taken the examination but not yet received a license from the board.

"Traineeship" means a period of full-time activity during which an unlicensed physical therapist or physical therapist assistant works under the direct supervision of a physical therapist approved by the board.

"Type 1" means face-to-face continuing learning activities offered by an approved organization as specified in 18 VAC 112-20-131.

"Type 2" means continuing learning activities which may or may not be offered by an approved organization but shall be activities considered by the learner to be beneficial to practice or to continuing learning. In Type 2 activities, licensees document their own participation on the Continued Competency Activity and Assessment Form and are considered self-learning activities.

18 VAC 112-20-130. Biennial renewal of license.

A. A physical therapist and physical therapist assistant who intends to continue practice shall renew his license biennially during his birth month in each even-numbered year and pay to the board the renewal fee prescribed in 18 VAC 112-20-150.

B. A licensee whose licensure has not been renewed by the first day of the month following the month in which renewal is required shall pay a late fee as prescribed in 18 VAC 112-20-150.

C. In order to renew an active license, a licensee shall be required to:

1. Complete a minimum of 320 hours of practice in the preceding four years ~~shall be required for licensure renewal;~~ and

2. Comply with continuing competency requirements set forth in 18 VAC 112-20-131.

18 VAC 112-20-131. Continued competency requirements for renewal of an active license.

A. In order to renew an active license biennially after December 31, 2003, a physical therapist or a physical therapist assistant shall complete at least 30 contact hours of continuing learning activities within the two years immediately preceding renewal. In choosing continuing learning activities or courses, the licensee shall consider the following: (i) the need to promote ethical practice, (ii) an appropriate standard of care, (iii) patient safety, (iv) application of new medical technology, (v) appropriate communication with patients, and (vi) knowledge of the changing health care system.

B. To document the required hours, the licensee shall maintain the Continued Competency Activity and Assessment Form that is provided by the board and that shall indicate completion of the following:

1. A minimum of 15 of the contact hours required for physical therapists and 10 of the contact hours required for physical therapist assistants shall be in Type 1 face-to-face courses. For the purpose of this section, "course" means an organized program of study, classroom experience or similar educational experience that is directly related to the

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clinical practice of physical therapy and approved or provided by one of the following organizations or any of its components:

- a. The Virginia Physical Therapy Association;*
- b. The American Physical Therapy Association;*
- c. Local, state or federal government agencies;*
- d. Regionally accredited colleges and universities;*
- e. Health care organizations accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO);*
- f. The American Medical Association - Category I Continuing Medical Education course; and*
- g. The National Athletic Trainers Association.*

2. No more than 15 of the contact hours required for physical therapists and 20 of the contact hours required for physical therapist assistants may be Type 2 activities or courses, which may or may not be offered by an approved organization but which shall be related to the clinical practice of physical therapy. Type 2 activities may include but not be limited to consultation with colleagues, independent study, and research or writing on subjects related to practice.

3. Documentation of specialty certification by the American Physical Therapy Association may be provided as evidence of completion of continuing competency requirements for the biennium in which initial certification or recertification occurs.

C. A licensee shall be exempt from the continuing competency requirements for the first biennial renewal following the date of initial licensure in Virginia.

D. The licensee shall retain his records on the completed form with all supporting documentation for a period of four years following the renewal of an active license.

E. The licensees selected in a random audit conducted by the board shall provide the completed Continued Competency Activity and Assessment Form and all supporting documentation within 30 days of receiving notification of the audit.

F. Failure to comply with these requirements may subject the licensee to disciplinary action by the board.

G. The board may grant an extension of the deadline for continuing competency requirements for up to one year for good cause shown upon a written request from the licensee prior to the renewal date.

H. The board may grant an exemption for all or part of the requirements for circumstances beyond the control of the licensee, such as temporary disability, mandatory military service, or officially declared disasters.

18 VAC 112-20-135. Inactive license.

A. A physical therapist or physical therapist assistant who holds a current, unrestricted license in Virginia shall, upon a request on the renewal application and submission of the

required renewal fee of \$70 for a physical therapist and \$35 for a physical therapist assistant, be issued an inactive license. From January 31, 2002, to January 1, 2004, the inactive renewal fee shall be \$30 for a physical therapist and \$15 for a physical therapist assistant.

1. The holder of an inactive license shall not be required to meet active practice requirements.

2. An inactive licensee shall not be entitled to perform any act requiring a license to practice physical therapy in Virginia.

B. A physical therapist or physical therapist assistant who holds an inactive license may reactivate his license by:

1. Paying the difference between the renewal fee for an inactive license and that of an active license for the biennium in which the license is being reactivated; and

2. Providing proof of:

a. Active practice hours in another jurisdiction equal to those required for renewal of an active license in Virginia for the period in which the license has been inactive. If the inactive licensee does not meet the requirement for active practice, the license may be reactivated by meeting the traineeship requirements prescribed in ~~subsection B of 18 VAC 112-20-140;~~ and

b. Completion of the number of continuing competency hours required for the period in which the license has been inactive, not to exceed four years.

18 VAC 112-20-136. Reinstatement requirements.

A physical therapist or physical therapist assistant whose Virginia license is lapsed and who is seeking reinstatement shall:

1. Practice physical therapy in another jurisdiction for at least 320 hours within the four years immediately preceding applying for reinstatement or successfully complete 480 hours as an inactive practice trainee as specified in 18 VAC 112-20-140; and

2. Complete the number of continuing competency hours required for the period in which the license has been lapsed, not to exceed four years.

18 VAC 112-20-140. Traineeship required.

~~A. A physical therapist or physical therapist assistant seeking reinstatement who does not hold a license in Virginia and who has not practiced physical therapy in another jurisdiction for at least 320 hours within the four years immediately preceding applying for licensure and who wishes to resume practice shall apply for reinstatement and shall first successfully complete 480 hours as an inactive practice trainee.~~

~~B. The 480 hours of traineeship shall be in a facility that (i) serves as a clinical education facility for students enrolled in an accredited program educating physical therapists in Virginia, (ii) is approved by the board, and (iii) is under the direction and supervision of a licensed physical therapist.~~

1. The physical therapist supervising the inactive practice trainee shall submit a report to the board at the end of the 480 hours on forms supplied by the board.

2. If the traineeship is not successfully completed at the end of the 480 hours, as determined by the supervising physical therapist, the president of the board or his designee shall determine if a new traineeship shall commence. If the president of the board determines that a new traineeship shall not commence, then the application for licensure shall be denied.

3. The second traineeship may be served under a different supervising physical therapist and may be served in a different organization than the initial traineeship. If the second traineeship is not successfully completed, as determined by the supervising physical therapist, then the application for licensure shall be denied.

NOTICE: The forms used in administering 18 VAC 112-20, Regulations Governing the Practice of Physical Therapy, are listed below. Any amended or added forms are reflected in the listing and are published following the listing.

FORMS

Application for a License to Practice Physical Therapy (Examination) (rev. 8/00).

Application for a License to Practice Physical Therapy (Endorsement) (rev. 8/00).

Application for Reinstatement of Licensure (rev. 8/00).

Instructions for Licensure by Endorsement to Practice as a Physical Therapist or Physical Therapist Assistant (Graduate of an Approved Program) (rev. 12/01).

Instructions for Licensure by Endorsement to Practice as a Physical Therapist or Physical Therapist Assistant (Graduate of a Nonapproved Program) (rev. 12/01).

Instructions for Licensure by Examination to Practice as a Physical Therapist or Physical Therapist Assistant (Graduate of an Approved Program) (rev. 12/01).

Instructions for Licensure by Examination to Practice as a Physical Therapist or Physical Therapist Assistant (Graduate of a Nonapproved Program) (rev. 12/01).

Instructions for Completing Reinstatement of Licensure Application for Physical Therapist/Physical Therapist Assistant (rev. 12/01).

The FSBPT Score Transfer Service, National Physical Therapy Examination (PT/PTA), Score Transfer Request Application (rev. ~~7/99~~ 7/00).

Traineeship Application, Statement of Authorization (rev. 8/00).

Traineeship Application, Statement of Authorization (1,000-hour traineeship) (rev. 8/00).

Traineeship Application, Statement of Authorization, Relicensure (480-hour traineeship) (rev. 8/00).

Relicensure Traineeship Certification (rev. 8/00).

Form #A, Claims History Sheet (rev. 7/00).

Form #B, Employment/Practice Verification of Physical Therapy (rev. 8/00).

Form #C, Verification of State Licensure (rev. 8/00).

Form #L, Certificate of Physical Therapy Education (rev. 7/00).

Renewal Notice and Application (rev. 12/01).

Continued Competency and Assessment Form (rev. 9/01).

Score Transfer Service Request

FEDERATION OF STATE BOARD OF PHYSICAL THERAPY

For Office Use Only
 Date _____
 By _____
 Fee _____

APPLICANT INFORMATION

Current Last Name _____ First _____ FE _____ SSN _____
 Most recent title of Exam, if different _____ Other Name _____ Date of Birth _____
 Current Address _____
 City _____ State/Province _____ Zip _____
 Email _____ Work Telephone _____ Home Telephone _____
 School from which Physical Therapy Degree Was Obtained _____ Graduation Date (month/year) _____

EXAM INFORMATION

☐ Physical Therapist ☐ Physical Therapist Assistant Exam Date _____

State applied for Examination _____

Candidate ID Number (305 only after 1996)

FEES

| State Transfer Fees* (LIST STATES BELOW) | FE | EXPEDITED FEE | SUBTOTAL |
|--|---|-----------------------------------|--|
| 1 st _____ | <input type="checkbox"/> \$60 <input type="checkbox"/> \$10 | <input type="checkbox"/> \$ _____ | \$ _____ |
| 2 nd _____ | <input type="checkbox"/> \$35 <input type="checkbox"/> \$10 | <input type="checkbox"/> \$ _____ | \$ _____ |
| 3 rd _____ | <input type="checkbox"/> \$35 <input type="checkbox"/> \$10 | <input type="checkbox"/> \$ _____ | \$ _____ |
| 4 th _____ | <input type="checkbox"/> \$35 <input type="checkbox"/> \$10 | <input type="checkbox"/> \$ _____ | \$ _____ |
| Individual Report Fee (\$35 PER EXAM) <small>*If appropriate FCIPT may be waived.</small> | | | <input type="checkbox"/> \$35 <input type="checkbox"/> \$10 x number of exams = \$ _____ |
| Total | | | \$ _____ |

PAYMENT

☐ Cashiers check ☐ Money order ☐ Certified check ☐ Corporate/business check
Personal checks are not accepted.
 Credit card: ☐ VISA ☐ MasterCard

 Credit Card Number: _____ Card Holder Name: _____ Signature: _____
 I certify that the information, which I have provided above, is correct. (Your request will not be processed unless it is signed.)

Signature _____

Date _____

Mail to:
 FSBPT Score Transfer Service, 500 Montgomery Street, Suite 120, Alexandria, VA 22314

Rev. 7-01-1997

FSBPT Score Transfer Service

FEDERATION OF STATE BOARDS OF PHYSICAL THERAPY

<https://www.fsbpt.net/jot>

APPLICATION INSTRUCTIONS

Note: Omissions or errors will result in delays. Please follow the instructions.

The FSBPT Score Transfer Service was established to facilitate the endorsement of licenses from one state to another. Your participation in this service is entirely voluntary. In offering this service, FSBPT makes no guarantees that any licensing board will accept a score transfer in lieu of other state requirements for the purposes of licensure.

You may transfer your scores on the National Physical Therapy Examination any time after taking the examination. Your scores are automatically reported to the board in the state (jurisdiction) in which you are seeking licensure and which you paid to take the examination. There is a reporting fee only when you transfer your scores to other states (jurisdictions).

You may submit an application for the FSBPT Score Transfer Service on the Internet at <https://www.fsbpt.net/jot> (note the "s" after "http"). It can also be printed from Score Transfer Service web site or you can complete and mail this form. You may also request this application form from the board of the state (jurisdiction) in which you seek endorsement/licensure. You may reach the Score Transfer Service at 800-200-2031 or scoretransfer@fsbpt.org. However, we do not accept faxed requests or requests made by phone.

Applicant Information

You must provide your current name, social security number, the complete name under which you took the examination (if different from your current name), date of birth, current address, daytime telephone number, physical therapy school, and month and year graduated.

Examination Information

You must provide the date (month, day, year), the state to which you applied and paid to take the examination, and your candidate ID number (the number that you wrote on the answer document at the time you tested). For those who tested in 1996 and later, their social security number is the candidate number. To verify this information, you may contact the board of the state to which you applied and which you paid to take the examination.

Fees

Transfer Fee The transfer fee is \$60.00 per examination for each licensing board for the first transfer to a state licensing board and \$35.00 for each additional state to which you want that score transferred. If the FSBPT Score Transfer Service (or its predecessor, Interstate Reporting Service) previously transferred the examination score, the transfer fee will be \$35.00 per state.

Expedited Service Fee You may request expedited service for an additional \$10.00 for each licensing board to which you want your PT or PTA scores transferred. This fee is in addition to the transfer fee. Processing time is 3 business days after we receive your request. (Note: There is no additional expedite fee if the request for transfer is made via our web site.)

Personal Copy/Individual Report Fee You may request a copy of your scores for yourself at \$35.00 per examination.

Method Of Payment

We accept credit cards (MasterCard/VISA only), certified check, cashier's check or money order made payable to Federation of State Boards of Physical Therapy. Personal checks will not be accepted.

Processing Your Request

Please allow 3 weeks from the date you mail your transfer request to FSBPT for the reporting of your scores to the licensing board(s). If you submit your transfer request via the Internet, the request should be processed within 1 week.

Mail to:

FSBPT Score Transfer Service
 500 Montgomery Street, Suite 120
 Alexandria, VA 22314

2

**Instructions for Completing
The CONTINUED COMPETENCY ACTIVITY AND ASSESSMENT FORM**

PART A: ACTIVITY

Learning Activity, Resources, Strategies & Experiences - List resources, strategies & experiences that you used to develop or maintain the selected knowledge or skill listed in Part B; e.g., conferences, quality improvement teams, consultations, discussions with colleagues, preceptorship, teaching, reading peer reviewed journals and textbooks, and self instructional media.

Date(s) of Activities - List the date(s) that you were engaged in the learning activity.

PART B: ASSESSMENT

Knowledge or Skills Maintained or Developed - Think about questions or problems encountered in your practice. Describe the knowledge or skills you addressed during the learning activity listed in Part A. Consider ethics, standards of care, patient safety, new medical technology, communication with patients, the changing health care system, and other topics influencing your practice.

HOURS/TYPE

Hours Actually Spent in Learning Activity: List the hours actually spent in the learning activity to nearest ½ hour. Total hours should be at least 30 hours biennially for physical therapists and physical therapist assistants.

Types of Activities: List the type of activity from the categories described below:

Type 1 continuing learning activities At least 15 hours for physical therapists and 10 hours for physical therapist assistants of the 30 hours required biennially

Must be offered by an approved organization that provides documentation of hours to the practitioner. All of the Type 1 hours must be earned in face-to-face or interactive courses.

Type 2 continuing learning activities No more than 15 hours for physical therapists and 20 hours for physical therapist assistants of the 30 hours required biennially

May or may not be approved by an approved organization but shall be activities considered by the learner to be beneficial to practice or to continuing learning; physical therapist and physical therapist assistants shall document their own participation on the attached form.

PART C: OUTCOME

Outcome - Indicate whether you will: a) make a change in your practice, b) not make a change in your practice, and/or c) need additional information on this topic. (You may include personal notes regarding the outcome of participating in this activity. e.g., learning activities you plan for the future, questions you need to answer or barriers to change.)

1

**VIRGINIA BOARD OF PHYSICAL THERAPY
CONTINUED COMPETENCY ACTIVITY AND ASSESSMENT FORM**

The Law

In 2001, the General Assembly of Virginia passed a law requiring regulations to ensure the continued competency of practitioners licensed by the Board of Physical Therapy. It directed the Board to include in its regulations continuing education, testing, and/or any other requirement which would address the following: a) the need to promote ethical practice, b) an appropriate standard of care, c) patient safety, d) application of new medical technology, e) appropriate communication with patients and f) knowledge of the changing health care system.

Rationale for the Regulation

The Virginia Board of Physical Therapy recognizes that the professional responsibility of practitioners requires continuous learning throughout their careers, appropriate to the individual practitioner's needs. The Board also recognizes that practitioners are responsible for choosing their own continuing education and for evaluating their own learning achievement. *The regulation of the Board is designed to encourage and foster self-directed practitioner participation in education.*

What is "Continuing Learning"? - Continuing learning includes processes whereby practitioners engage in activities with the conscious intention of bringing about changes in attitudes, skills, or knowledge, for the purpose of identifying or solving ethical, professional, community or other problems which affect the health of the public.

Content of the Regulation

Number of Hours Required:

In order to renew an active license biennially, the practitioner must complete the CONTINUED COMPETENCY ACTIVITY AND ASSESSMENT FORM, which is provided by the Board and must indicate completion of at least 30 hours of continuing learning activities for physical therapists and physical therapist assistants.

At least 15 of the hours required for physical therapists and at least 10 of the hours required for physical therapist assistants shall be Type 1 continuing learning activities as documented by an approved organization to designate learning activities for credit or other value. All of the Type 1 hours must be earned in face-to-face settings, interactive courses or other interaction with peers. All required hours may be Type 1.

No more than 15 of the hours required for physical therapists and no more than 20 of the hours required for physical therapist assistants may be Type 2 continuing learning activities which may or may not be approved for credit by an approved organization. Physical therapists and physical therapist assistants shall document their own participation in Type 2 learning activities.

Maintenance and audit of records:

The CONTINUED COMPETENCY ACTIVITY AND ASSESSMENT FORM must be used for recording continuing learning activities. The practitioner is required to retain in his or her records the completed form with all supporting documentation for a period of four years following the renewal of an active license.

The Board will periodically conduct a random audit of a percentage of its active licensees to determine compliance. The practitioners selected for the audit must provide the completed CONTINUED COMPETENCY ACTIVITY AND ASSESSMENT FORM and any supporting documentation within 30 days of receiving notification of the audit.

CONTINUED COMPETENCY ACTIVITY AND ASSESSMENT FORM

Please photocopy this original form to record your learning activities.

The completed forms and all documentation must be maintained for a period of four years.

| PART A: ACTIVITY | | PART B: ASSESSMENT | # OF HOURS/TYPE | | PART C: OUTCOME |
|--|------|--|---|---|--|
| Learning Activity, Resources, Strategies & Experiences; e.g. conferences, consultations, teaching, peer-reviewed journals, quality improvement teams, self- instructional material | Date | Knowledge or Skills You Maintained or Developed. What questions or problems encountered in your practice were addressed by this learning activity? | Type 1 Minimum of 15 hrs. for PT and 10 hrs. for PTA | Type 2 No more than 15 hrs. for PT and 20 hrs. for PTA | Outcome: Indicate whether you will: a) make a change in your practice, b) not make a change in your practice, and/or c) need additional information on this topic. |
| | | | | | |
| | | | | | |
| | | | | | |

As required by law and regulation, I certify that I have completed the CONTINUED COMPETENCY ACTIVITY AND ASSESSMENT FORM and have participated in 30 hours of continuing learning activities as required for renewal of a physical therapy or a physical therapist assistant license in the Commonwealth of Virginia.

Signature _____

Date _____

BOARD OF COUNSELING

Title of Regulation: 18 VAC 115-60. Regulations Governing the Licensure of Substance Abuse Treatment Professionals (adding 18 VAC 115-60-55).

Statutory Authority: §§ 54.1-2400 and 54.1-3508 of the Code of Virginia.

Public Hearing Date: May 31, 2002 - 1:30 p.m.

Public comments may be submitted until July 19, 2002.

(See Calendar of Events section for additional information)

Agency Contact: Elaine J. Yeatts, Agency Regulatory Coordinator, Department of Health Professions, 6606 W. Broad Street, 4th Floor, Richmond, VA 23230, telephone (804) 662-9918, FAX (804) 662-9114, or e-mail elaine.yeatts@dhp.state.va.us.

Basis: Section 54.1-2400 of the Code of Virginia establishes the general powers and duties of health regulatory boards including the responsibility to promulgate regulations, levy fees, administer a licensure and renewal program, and discipline regulated professionals.

Section 54.1-3508 of the Code of Virginia specifically mandates that the board establish a time-limited provision for licensure of individuals who do not meet the requirements in current regulation, but have qualifications that are "acceptable" to the board.

Purpose: If the board does not develop a time-limited provision for licensure of individuals who do not meet all of the licensure requirements, it will be out of compliance with the legislative mandate. In the effort to develop requirements, the board has taken into consideration the kinds of education and experiences that will protect the public health and safety by conferring competency for independent practice, which includes the ability to identify psychological and emotional problems that coexist with the substance abuse, and appropriately refer clients for treatment of these problems. A considerable amount of public comment received during development of the new regulations addressed the fact that formal educational opportunities in this emerging profession have been scarce, and many of the most highly skilled counselors gained their knowledge from a combination of courses, workshops, seminars and independent study. In an effort to be inclusive of professionals who have obtained their training from a wide variety of sources, the board developed combinations of education and experience, which it feels provide equivalent training for competent independent practice.

In order to implement the mandate of § 54.1-3508 of the Code of Virginia, the board must establish a regulation setting forth criteria that it would consider acceptable for granting licensure to individuals, which will authorize them to provide substance abuse treatment services independently. The board established the current education and experience requirements based on what it determined were the minimum requirements to ensure safe and competent independent practice to protect the health and safety of the clients using the services of these practitioners. The new mandate challenged the board to develop additional avenues for

licensure, which will ensure the same level of competence as the current regulation and afford the same protection to the public engaging the services of licensees.

Substance: The board is proposing a new section to the regulation that will establish two alternative combinations of education and work experience in substance abuse, which will qualify individuals for licensure during a one-year period. Individuals in all categories will have to hold a current Virginia certification in substance abuse in good standing, pass a board approved examination in substance abuse, and submit comprehensive reports from three licensed mental health professionals, one of which must be licensed in Virginia affirming competence in all areas of practice.

Issues:

Advantages to applicants: Qualified individuals who have spent many years in the substance abuse treatment profession, but find attainment of a master's degree with 60 graduate hours unfeasible, will have an avenue to obtain the license. Licensure will grant these individuals the authority to practice independently, which they cannot currently do with the certification. Licensure will open more job opportunities in the public and private sector where licensure is required.

Disadvantages to applicants: There will be no disadvantages to potential applicants. Some individuals who already hold licenses under the board have submitted comment that the waiver would reduce the integrity of the license and impact third party payments, but the board cannot predict how third party payors will respond to requests for payments by those licensed under the waiver.

Advantages to the public: There will be a greater availability of licensed therapists with expertise in substance abuse treatment who can offer services in both the public and private sectors. Since settings exempt from licensure requirements (primarily government and nonprofit agencies) are increasingly requiring licensure for their staff in order to obtain third party payments, there will be a greater pool of individuals trained in substance abuse that they may consider hiring to provide substance abuse treatment services.

Disadvantages to the public: There will be no disadvantages to the public:

Advantages or disadvantages to government agencies: Agencies who now hire other licensed professionals, but might want someone with more substance-abuse specific experience, will have a larger group of individuals to choose from.

Department of Planning and Budget's Economic Impact Analysis:

The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007 G of the Administrative Process Act and Executive Order Number 25 (98). Section 2.2-4007 G requires that such economic impact analyses include, but need not be limited to, the projected number of businesses or other entities to whom the regulation would apply, the identity of any localities and types of businesses or other entities particularly affected, the projected number of persons and employment positions to be affected, the projected costs to affected businesses or entities to implement or comply with

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the regulation, and the impact on the use and value of private property. The analysis presented below represents DPB's best estimate of these economic impacts.

Summary of the proposed regulation. Chapter 863 of the 1999 Acts of Assembly amended § 54.1-3508 of the Code of Virginia to require the Board of Counseling to develop alternative licensure requirements for substance abuse treatment professionals who do not meet the board's licensure requirements exactly, but in the board's judgment are qualified to practice independently. In response to that mandate, the Board of Counseling is proposing a one-year waiver of current licensure requirements for individuals who may have spent many years in the profession but find the licensure requirements (i.e., a master's degree with 60 graduate hours) unfeasible.

To be eligible for licensure during the one-year waiver period, individuals will have to hold a current Virginia certification in substance abuse counseling in good standing, pass a board approved examination in substance abuse treatment, submit comprehensive reports from three licensed mental health professionals affirming competence in all areas of practice, and meet one of two combinations of education and work experience in substance abuse treatment.

Estimated economic impact. Formal education opportunities in the emerging substance abuse treatment profession have been scarce. Many of the most highly skilled counselors have gained their knowledge from a combination of courses, workshops, seminars, and independent study. The proposed "grandfather clause" provides an avenue for individuals who have substantial education and experience in substance abuse treatment, but do not meet the current requirements to obtain licensure. Licensure allows these individuals to practice independently and opens more employment opportunities in private settings and public sectors where employers are increasingly requiring licensure for their staff in order to obtain third party payments.

The cost of obtaining the license will vary from individual to individual. For individuals who choose this route or employers who choose to underwrite these costs for their staff, the costs can be expected to be less than the benefits of obtaining licensure. By granting licensure to individuals who, in the board's opinion, are qualified and possess the same level of competence, the proposed provision has the potential to increase the supply of licensed providers without compromising the level of protection provided to the public engaging the services of licensees. The education, examination, and experience requirements set by board are based on the board's judgment, and there is no information available to independently assess whether they ensure the same level of competence as the current licensure standards.

The requirement that an applicant must have a current Virginia board certification as a substance abuse counselor, however, does not appear to provide any additional benefit to justify the costs imposed on applicants. The education, experience, and testing requirements for licensure are considerably more comprehensive and rigorous than those required for certification and would provide no additional assurance of an individual's ability to practice independently. The board argues that the requirement will provide a

disciplinary history, yet there is nothing specifying the length of time the applicant must be certified, and for individuals applying under the one-year waiver provision, the relatively short period of certification would fail to provide any meaningful record of discipline-free certified practice.

While many of the applicants for licensure under the proposed grandfather clause are likely to already have the Virginia board certification, there are potentially many practitioners who may have chosen to obtain a national certification, which is frequently more rigorous than state certification, to demonstrate their skills and abilities or who may be working in a setting where credentialing is not required. For these otherwise qualified applicants, the certification requirement is burdensome and costly with no apparent value.

Businesses and entities affected. The proposed regulatory provision will affect certain qualified substance abuse treatment counselors who do not meet the current requirements for licensure. The board estimates approximately 100 of the 1,200 Virginia certified substance abuse counselors might seek licensure under the waiver provisions. In addition, there may also be qualified individuals without a Virginia board certification who may apply for licensure under the proposed waiver provision.

Localities particularly affected. The proposed changes to this regulation will not uniquely affect any particular localities.

Projected impact on employment. The proposed changes to this regulation are not likely to affect the overall level of employment in Virginia. However, providing the waiver may open more employment opportunities in private settings and public sectors where employers are increasingly requiring licensure for their staff in order to obtain third party payments.

Effects on the use and value of private property. The proposed changes to this regulation are not likely to affect the use and value of private property in Virginia.

Agency's Response to the Department of Planning and Budget's Economic Impact Analysis: The Board of Counseling concurs with the analysis of the Department of Planning and Budget for 18 VAC 115-60.

Summary:

The board is proposing a one-year waiver of the licensure requirements in the current regulations for individuals who hold certain combinations of education and work experience in substance abuse. This is in compliance with a statutory mandate that the board provide for a time period of not less than one year whereby individuals who possess qualifications, education or experience acceptable to the board will be granted the license.

18 VAC 115-60-55. Time-limited waiver of certain licensure requirements.

Until (insert date for one year following effective date of regulation) individuals who do not meet the licensure requirements set forth in 18 VAC 115-60-50 and 18 VAC 115-60-60 through 18 VAC 115-60-90 may be eligible for licensure if they submit a completed application, processing fee, and provide evidence that they meet the following criteria:

1. A current Virginia board certification as a substance abuse counselor in good standing;
2. A passing score on a board-approved examination;
3. Comprehensive reports from a minimum of three licensed mental health professionals, of which one must be licensed in Virginia, that affirm competence in all areas outlined in 18 VAC 115-60-80 C 1 and attest to the applicant's ability to practice autonomously; and
4. One of the following:

a. Five years full-time experience in substance abuse treatment plus a master's degree in a mental health field from a regionally accredited institution of higher learning with a total of 36 graduate hours covering mental health content to include three graduate semester hours or 4.5 graduate quarter hours in each area of the following:

- (1) Counseling and psychotherapy techniques;
- (2) Appraisal, evaluation and diagnostic procedures;
- (3) Abnormal behavior and psychopathology;
- (4) Group counseling and psychotherapy, theories and techniques; and
- (5) Research.

The remaining graduate semester hours shall include content in the following areas:

- (1) Assessment, appraisal, evaluation and diagnosis specific to substance abuse;
- (2) Treatment planning models, client case management, interventions and treatments to include relapse prevention, referral process, step models and documentation process;
- (3) Understanding addictions: The biochemical, socio-cultural and psychological factors of substance use and abuse;
- (4) Addictions and special populations, including, but not limited to, adolescents, women, ethnic groups and the elderly; and
- (5) Client and community education; or

b. Ten years full-time experience in substance abuse treatment plus a bachelor's degree from a regionally accredited institution of higher learning, plus 30 graduate hours covering mental health content to include three graduate semester hours or 4.5 graduate quarter hours in each area of the following:

- (1) Counseling and psychotherapy techniques;
- (2) Appraisal, evaluation and diagnostic procedures;
- (3) Abnormal behavior and psychopathology;
- (4) Group counseling and psychotherapy, theories and techniques; and
- (5) Research.

The remaining graduate hours shall include content in the following areas:

- (1) Assessment, appraisal, evaluation and diagnosis specific to substance abuse;
- (2) Treatment planning models, client case management, interventions and treatments to include relapse prevention, referral process, step models and documentation process;
- (3) Understanding addictions: the biochemical, socio-cultural and psychological factors of substance use and abuse;
- (4) Addictions and special populations, including, but not limited to, adolescents, women, ethnic groups and the elderly; and
- (5) Client and community education.

VA.R. Doc. No. R01-34; Filed May 1, 2002, 10:42 a.m.

TITLE 22. SOCIAL SERVICES

STATE BOARD OF SOCIAL SERVICES

Title of Regulation: **22 VAC 40-705. Child Protective Services (amending 22 VAC 40-705-10, 22 VAC 40-705-30 through 22 VAC 40-705-90, 22 VAC 40-705-110 through 22 VAC 40-705-160, 22 VAC 40-705-180, and 22 VAC 40-705-190).**

Statutory Authority: §§ 63.1-25 and 63.1-248.6 of the Code of Virginia.

Public Hearing Date: June 12, 2002 - 1 p.m.

Public comments may be submitted until July 19, 2002.

(See Calendar of Events section for additional information)

Agency Contact: Betty Jo Zarris, CPS Policy Specialist, Department of Social Services, Theater Row Building, 730 East Broad Street, 2nd Floor, Richmond, VA 23219, telephone (804) 692-1220, FAX (804) 692-2215, or e-mail bjz900@dss.state.va.us.

Basis: Chapter 12.1 (§ 63.1-248.2 et seq.) of Title 63.1 of the Code of Virginia places responsibility for providing protective services for children with the Department of Social Services. Section 63.1-25 places authority with the Board of Social Services to make rules and regulations consistent with Title 63.1 of the Code of Virginia. These changes are necessitated by legislation enacted by the 2000 General Assembly session. Chapter 500, 2000 Acts of Assembly made changes to Title 63.1 of the Code of Virginia in § 63.1-248.2 et seq. and required that regulations be promulgated to take effect within 280 days of enactment. The emergency regulations are currently in effect but due to expire December 31, 2002.

Purpose: This regulatory action is intended to promote the safety and well-being of children within their families in Virginia. Until the enactment of this legislation, all valid reports

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of child abuse or neglect had to be investigated and a finding made as to abuse or neglect by an alleged abuser. The legislation enacted in 2000 and these regulations allow for a response to valid reports of less serious abuse or neglect that is less adversarial and more likely to engage families in services, if needed, to protect their own children.

These permanent regulations are being developed to provide more details regarding determining the most appropriate response to a valid report and providing services to prevent child abuse or neglect. They will replace the emergency regulations and provide other needed changes.

Substance: Changes to language are made wherever needed to incorporate family assessment as a response to a valid child protective services (CPS) report.

22 VAC 40-705-10: Provides definitions for "differential response" and "family assessment." (The definition of "family assessment" can easily be compared to that of "investigation" to see what is similar and different about these processes.) Also codifies definition of "valid" that has always been in CPS policy.

22 VAC 40-705-40 H 4: Reflects a change in the Code of Virginia that instructs the juvenile and domestic relations court judge to assign the report on any local department employee to another local department. It deletes the judge's former option to assign the report to the court services unit.

22 VAC 40-705-50 A: Adds a time frame for screening complaints.

22 VAC 40-705-50 B: After receiving a report of child abuse and/or neglect, the local department is required to decide at intake whether to conduct an investigation or a family assessment.

22 VAC 40-705-50 E: Encourages memoranda of understanding between local social services agencies and law-enforcement agencies.

22 VAC 40-705-50 F 4: Requires the department to report child fatalities to the state board, as requested by the board.

22 VAC 40-705-50 H: Clarifies when an investigation is the required response to a valid report of child abuse or neglect.

22 VAC 40-705-50 H 2: Delineates the purpose of a family assessment.

22 VAC 40-705-60 3 b: Requires reassignment of a family assessment to investigation if the agency takes emergency custody of the child.

22 VAC 40-705-70 B: Emphasizes collaboration with the family in family assessments.

22 VAC 40-705-70 C: Clarifies required documentation of all information gathered in a family assessment or an investigation, as requested by the board.

22 VAC 40-705-80 A: Outlines required contacts to be made by the local agency when completing family assessments.

22 VAC 40-705-90 A: Outlines the conditions in which a CPS worker in both family assessments and investigations may

enter a home if permitted by a person who resides in the home.

22 VAC 40-705-90 B: Requires the CPS worker to explain orally and in writing the responsibilities and authorities of CPS in order to make the parent or caretaker aware of the benefits and consequences of completing the family assessment or investigation.

22 VAC 40-705-110: Clarifies the types of assessments required in both the family assessment response and the investigation response.

22 VAC 40-705-120 B & C, 22 VAC 40-705-140 B 5 & D 3: These sections address required notifications for the new family assessment response. 22 VAC 40-705-140 B 5 also notes that no disposition is made in a family assessment.

22 VAC 40-705-140 C 3: Reflects a statutory change that allows a child's name to be entered in the central registry in situations where the abuse occurred in a designated out-of-family setting and the parent or guardian was not the abuser only if the parent or guardian is consulted and agrees to the name entry.

22 VAC 40-705-150 A: Emphasizes planning for services in consultation with the family whenever possible.

22 VAC 40-705-150 B: Addresses the right of families to refuse services offered as the result of a completed family assessment.

22 VAC 40-705-150 C: Notes that court intervention to mandate services may be requested to engage families in needed services to prevent abuse/neglect.

22 VAC 40-705-180 C: Requires local child protective services staff to receive training in order for the agency to become "designated" as a differential response agency.

Issues: Since the primary changes to the regulations involve the continuing implementation of a differential response system, the advantages and disadvantages of those changes to the regulations are addressed here. The public is generally expected to benefit from a revised CPS system. A premise of the CPS reforms is an increased investment in services and supports for these vulnerable children and families both by state systems and community-based organizations. Primary changes expected with implementation of a differential response system:

1. Community collaboration in family needs assessments and provision of services to CPS families – this can range from involving other community groups and organizations in determining service gaps, to encouraging them to serve on assessment teams, to forging new or stronger memoranda of understanding with key players, such as health departments or Community Services Boards;
2. A differential response (DR), rather than just an investigation methodology, for different types of child abuse/neglect reports;
3. An emphasis shift from labeling families in need of prevention services to identifying and providing services to promote safe family relationships;

4. An intervention shift from disposition focus to building on family strengths and family perception of needs to protect the child;

5. Also, a shift to allowing/encouraging worker/family partnerships in most cases (the pilots responded with a family assessment to over two-thirds of their valid reports).

The only expected disadvantage to implementation of a differential response system may be an increased identification of family and individual service needs, as local agencies are better able to partner with families. There was some indication in the pilots of increased need identification, but the statewide impact will take a year or two to determine. In these difficult economic times, meeting any increased needs may prove frustrating for local communities.

Department of Planning and Budget's Economic Impact Analysis: The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007 G of the Administrative Process Act and Executive Order Number 25 (98). Section 2.2-4007 G requires that such economic impact analyses include, but need not be limited to, the projected number of businesses or other entities to whom the regulation would apply, the identity of any localities and types of businesses or other entities particularly affected, the projected number of persons and employment positions to be affected, the projected costs to affected businesses or entities to implement or comply with the regulation, and the impact on the use and value of private property. The analysis presented below represents DPB's best estimate of these economic impacts.

Summary of the proposed regulation. The proposed regulations will establish a differential response system for child abuse/neglect reports received by the local Child Protective Service departments. The proposed differential response system will allow the local departments to utilize a family assessment track in addition to the investigation track utilized in the singular response system that was effective prior to the emergency regulations. Additionally, the proposed regulations will require a memorandum of understanding to be developed by local departments of social services with local law enforcement and the local office of the Commonwealth's Attorney.

The proposed changes have been in effect since January 1, 2002, as emergency regulations. However, the proposed changes are currently effective only in five pilot localities because the local departments are required to provide training for workers prior to implementing the proposed family assessment track. The Department of Social Services indicates that the local departments are in the process of completing the training requirements and anticipates that by May 1, 2002, all of the local departments will have provided the required training to their employees and start implementing the proposed differential response system.

Estimated economic impact. Child Protective Services regulations contain procedures for handling of child abuse/neglect reports. Local Child Protective Service departments receive and respond to the abuse/neglect complaints. In fiscal year (FY) 2001, 121 local departments

received 47,253 child abuse and neglect reports.¹ When a report is received, the local department determines whether the report is valid. In FY 2001, about 30,362 reports were determined valid.² If the report is valid, the local department conducts an investigation. A child abuse/neglect investigation is a fact-finding process in which information is collected and analyzed in order to determine if child abuse or neglect has occurred, to identify responsible persons, and to assess risk of future maltreatment. The investigations may include talking with the alleged child victim, parents, and/or alleged perpetrator, gathering medical and psychological information, and talking with other professionals or persons who have knowledge of the child's situation. Prior to the emergency regulations, the local departments were required to conduct an investigation for all the valid abuse/neglect reports received.

Pursuant to the statutory changes, the proposed regulations will allow local departments to conduct a family assessment rather than an investigation for some cases. The departments will continue to conduct investigations when there are immediate child safety concerns and/or the abuse/neglect report indicates serious allegations including sexual abuse, fatality, serious injury, hospitalization, abandonment, etc. With the proposed changes, the local departments will be allowed to consider a family assessment response for reports when there are no immediate child safety concerns and/or the report does not indicate serious allegations. For example, a family assessment may be conducted for reports indicating minor physical injury, lack of supervision, failure to consistently meet food, clothing, shelter, and hygiene needs of the child, presence of untreated injuries, illnesses, impairments, emotional abuse/neglect, etc. The departments will have authority to move a case from the family assessment track to investigation track if needed. In short, the proposed regulations will establish a differential response system allowing the departments to respond to complaints in two different ways. The departments will either investigate the valid report or conduct a family assessment.

The main effect of the proposed changes is that the number of investigations will decrease and family assessment approach will be utilized in a significant number of cases. Data from the five pilot areas indicate that for the 1,547 valid reports received in FY 2001, about 1,116 (72%) were responded through a family assessment instead of an investigation.³ If this percentage is representative for the rest of the state, then about 21,861 of the 30,362 valid reports that may be received in a year are likely to be responded through a family assessment instead of an investigation.

There are significant differences between an investigation and a family assessment. For every investigation, the local department has to make a finding as to whether abuse/neglect occurred. If the complaint is founded, the name of the abuser is recorded to Central Registry of Founded Child Abuse and Neglect for 3 to 18 years depending on the type and severity

¹ Source: The Department of Social Services.

² Ibid.

³ Source: Final Report on the Multiple Response System for Child Protective Services in Virginia, Department of Social Services, December 1999.

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of the incident. On the other hand, a family assessment will not require the department to make a disposition. No finding of abuse/neglect will be made and no information will be recorded to the department's central registry. The assessment will be used to identify the family needs related to prevention of child maltreatment. For example, the local department will focus on whether the family understand child development, whether there is need for education about parenting, whether the child is a special needs child, whether individual counseling is needed, and whether there is need for department's assistance with medical treatment.

Staff time and other resources required from the local departments to process valid abuse/neglect complaints may be different for investigations and for family assessments. Both require determination of immediate safety and rehabilitative needs of the child, risk of future harm, and developing alternate plans when appropriate. In addition to these, an investigation requires determination on whether abuse/neglect occurred and identification of the person who abused or neglected the child. Thus, it seems that the proposed differential response system would require less economic resources than current singular response system in responding to abuse/neglect reports because in most cases a family assessment will be conducted instead of an investigation. However, the Department of Social Services indicates that because of other factors, the family assessment approach has the potential to increase the resources needed to process valid abuse/neglect complaints.

It is indicated that during the three-year pilot program, families have shown higher cooperation with the department workers in family assessments relative to investigations. About 76% of CPS workers in the pilot areas believed that families felt less threatened and about 70% believed that families were more willing to discuss their problems with Child Protective Services.⁴ This is attributed to procedural differences in conducting family assessments. In an investigation, the caseworker is required to inform the family that they have the right to refuse providing information. This requirement is believed to reduce family participation. In a family assessment, on the other hand, the caseworker is not required to provide this warning. Additionally, no determination of whether abuse or neglect occurred is made in a family assessment and no names are recorded in the department's central registry. As a result, families seem to engage more in family assessments and tend to cooperate more with the caseworker. Thus, conducting a family assessment may take more than or just as much time as conducting an investigation. According to the 1999 evaluation, about 64% of the workers in pilot localities believed the total time needed for all casework was greater under the differential response system, about 53% believed providing and arranging services took longer, and 47% believed direct contacts with the family took more time. Although this information indicates that the differential response approach may increase the staff time and other department resources to respond to an abuse/neglect report, the data from the pilot areas also indicates that the same number of workers was able to handle approximately the same number of complaints. Thus, no conclusive

statements can be made on whether the processing time for the reports received will increase or not.

Additionally, the initial analysis of the multiple response system conducted in 1999 indicates that the percent of investigations that are founded increased from 21% to 42%. This is expected because serious valid reports were placed under the investigation tract. This suggests that the resources devoted to investigation of valid complaints are more efficiently used and the department may save some resources from not investigating complaints that are not founded.

Also, there is no appeal process for family assessments. Since, in most cases, a family assessment is likely to be conducted instead of an investigation, the number of appeal cases is likely to decrease. The appeal process is a three-tier process. The first step of the appeal process is a conference between the alleged abuser and the local department. This conference gives the alleged abuser a chance to submit pertinent information that can change the disposition of the complaint. In 1995, the department received 532 appeals at the local level. However, in some cases, a predisposition consultation may be arranged prior to the local conference. When the local department believes that the report will be founded, alleged abuser may request a predisposition consultation. Based on the consultation, the alleged abuser may waive the local conference and proceed to the appeal process at the state level. If the appeal is not resolved at the local level, the alleged abuser may request an administrative hearing at the state level. A hearing officer conducts this hearing. In 1995, 225 state level appeals were received. Alleged abuser has the right to appeal the disposition upheld at the state level administrative hearing to the Circuit Court. In 1995, 28 appeals were brought to the court.

The appeal costs include costs to hold conferences at the local level, to hold hearings at the state level, and potential litigation costs to appeal to the court. The main costs are staff time required to prepare, review, and attend the hearings. A caseworker prepares the hearing, a supervisor reviews the work, and both attend the local conference. In addition to the local conference, the caseworker and supervisor attend the hearing at the state level if the decision at the local level is appealed. Thus, the local departments are expected to save some staff time because the number of appeals at the local and state levels are likely to decrease. At the state level appeals, participation of a hearing officer is required. Thus, the proposed changes is also likely to provide some cost savings to the Department of Social Services by reducing the number of appeals at the state level. Finally, if the number of cases going to the court decreases there may be some litigation cost savings. Similarly, the time and resources devoted by alleged abusers in appeal process are likely to decrease.

There may be other benefits from the family assessment approach. This approach places more emphasis on child's safety and development needs than abuse/neglect investigations where the focus is on evidence collection and determining whether the incident occurred or not. A family assessment seems to have higher potential to allow families to learn about the potential causes of child's problems, educate families, and help stop unintentional abuse/neglect.

⁴ Ibid.

Education aspect of the family assessment may improve child's welfare and reduce the recidivism rates. About 1.7% of abused/neglected children reported in FY 2000 were involved in a subsequent founded report of abuse/neglect within a year.⁵ Also, of the 30 children died because of abuse/neglect in FY 2001, five were involved in a prior founded Child Protective Services report.

On the other hand, the proposed changes will increase the training requirements because an additional decision will have to be made at the intake and the new family assessment track is being introduced. Intake staff will have to make a decision on whether to conduct an investigation or a family assessment in addition to their evaluations on the validity and the urgency of the complaints. To assist the existing intake staff in making this decision and all Child Protective Services staff in implementing a differential response to valid reports of abuse/neglect, additional training will be provided. The department will conduct 12 hours of training at five regional offices over two days. About 1,350 current employees are expected to attend the training. Thus, about 16,200 hours of staff time for training and associated travel expenses and time should be considered as additional costs to the department. Additionally, new employees will likely be required to attend about four hours of additional training to learn about the differential response system.

In addition to two-day training, the department plans to conduct a one-day nonmandatory training at the regional offices. This training will be used to enhance the skills of caseworkers in engaging families in a family assessment. The department does not expect more than 200 employees to attend this training. Thus, about 1,200 hours of staff time for the training and travel expenses and time can be attributed to the proposed changes.

Moreover, the department will modify the information system used to manage the abuse/neglect cases. A new module has been created within the information system to document the work done on each family assessment case. Modifications may be needed as a result of the statewide implementation. The department does not know the size of the costs already incurred and the size of the costs that may be incurred in the future to make additional modifications.

Furthermore, the department has a contract with a university to evaluate annually the differential response system for at least three years. The first year evaluation cost is about \$38,000 and will likely be repeated two more years.

Additionally, the family assessment approach is likely to increase service costs because more family needs will be identified. The initial analysis indicates that the percent of cases where service needs identified increased from 54% to 75%. More service needs may increase the staff time needed or the average employee workload and increase the costs associated with providing identified needs. These services include counseling/therapy, medical care, diagnostics and evaluation services, and childcare. However, these additional costs will likely be subject to availability of funds and the

services and the family's willingness to receive the services. Also, the department expects additional difficulties at the early stages of the family assessment implementation due to unfamiliarity with the proposed system. These difficulties are expected to decrease as employees gain experience in the proposed differential response system.

Finally, the effect of proposed regulations on child safety is probably the most significant albeit the most difficult issue to evaluate. The 1999 evaluation indicate that most mandated reporters in the pilot localities believe the differential system increased child safety. Mandated reporters include teachers, doctors, nurses, day care providers who are legally required to report suspected abuse/neglect. About 65% of the mandated reporter and CPS worker responders believed that child safety was improved, about 30% believed that it had no impact, and 5% believed that it reduced child safety.

Another proposed amendment will require a memorandum of understanding to be developed by local Child Protective Services departments with local law enforcement and the local office of the Commonwealth's Attorney. This is expected to encourage collaboration among law-enforcement agencies, attorney services, and local departments. Some localities have already developed a memorandum of understanding. This document will establish roles and responsibilities and improve relationships between the three agencies. The memorandum of understanding is likely to prevent overlapping duties. Also, it is likely to reveal which service areas are not covered. The costs associated with developing this document is expected to be small.

Businesses and entities affected. The proposed regulations are expected to affect 121 local departments of social services. In addition, alleged child victims and their families and alleged perpetrators involved in about 30,300 valid abuse/neglect reports may be affected in a year.

Localities particularly affected. The proposed regulations apply throughout the Commonwealth.

Projected impact on employment. The proposed regulations are likely to increase the need for child and family service needs such as counseling/therapy services, medical care services, diagnostic and evaluation services, and child care services. Thus, the proposed family assessment track may have a positive impact on employment in these service areas.

The net effect of the proposed changes on local departments' employee needs is not known. Some of the provisions are likely to increase the staff time required to respond to child abuse/neglect reports and some others are likely to decrease it. Thus, no conclusive statement can be made on the labor demand of the local social service departments.

Effects on the use and value of private property. If the increased demand for child and family services causes a significant increase in business volume and increase profitability, a positive impact on the value of such service providers is expected.

Agency's Response to the Department of Planning and Budget's Economic Impact Analysis: The Department of Social Services concurs with the overall findings of the

⁵ This rate is believed to be an undercount due to problems with the use of the information system.

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analysis. There are, however, several items in the report that bear clarification:

1. On the bottom of page 1, we need to be clear that the local departments are attending the statewide training, not providing it.
2. At the top of page 4, we would add that the major reason the Department indicated the family assessment approach may increase needed resources is because more service needs were identified in the pilot localities.
3. In the next paragraph on page 4, we just want to be clear that even though a CPS worker conducting a family assessment is not required to use the "refuse entry" language that is in the regulations currently for investigations, the worker only enters the home when allowed to do so by an adult in the home.

Summary:

The proposed amendments establish a differential response system for child abuse/neglect reports received by the local child protective services departments. The differential response system will allow the local departments to utilize a family assessment track or an investigation track, as appropriate. Other proposed amendments (i) require a memorandum of understanding to be developed by local departments of social services with local law enforcement and the local office of the commonwealth's attorney and (ii) require the department to report child fatalities to the state board.

22 VAC 40-705-10. Definitions.

The following words and terms, when used in this chapter, shall have the following meanings unless the context clearly indicates otherwise.

"Abuser or neglector" means any person who is found to have committed the abuse and/or neglect of a child pursuant to Chapter 12.1 (§ ~~63.1-248.1~~ 63.1-248.2 et seq.) of Title 63.1 of the Code of Virginia.

"Administrative appeal rights" means the child protective services appeals procedures for a local level informal conference and a state level hearing pursuant to § 63.1-248.6:1 of the Code of Virginia, under which an individual who is found to have committed abuse and/or neglect may request that the local department's records be amended.

"Appellant" means anyone who has been found to be an abuser and/or neglector and appeals the founded disposition to the director of the local department of social services, an administrative hearing officer, or to circuit court.

"Assessment" means the process by which child protective services workers determine a child's and family's needs.

"Caretaker" means any individual having the responsibility of providing care for a child and includes the following: (i) parent or other person legally responsible for the child's care; (ii) any other person who has assumed caretaking responsibility by virtue of an agreement with the legally responsible person; (iii) persons responsible by virtue of their positions of conferred

authority; and (iv) adult persons residing in the home with the child.

"Case record" means a collection of information maintained by a local department, including written material, letters, documents, tapes, photographs, film or other materials regardless of physical form about a specific child protective services investigation, family or individual.

"Central Registry" means a subset of the *child abuse and neglect* information system and is the name index with identifying information of individuals named as an abuser and/or neglector in founded child abuse and/or neglect complaints or reports not currently under administrative appeal, maintained by the department.

"Certified substance abuse counselor" means a person certified to provide substance abuse counseling in a state-approved public or private substance abuse program or facility.

"Child abuse and neglect information system" means the computer system which collects and maintains information regarding incidents of child abuse and neglect involving parents or other caretakers. The computer system is composed of three parts: the statistical information system with nonidentifying information, the Central Registry of founded complaints not on appeal, and a database that can be accessed only by the department and local departments ~~consisting of that contains all nonpurged investigation information~~ CPS reports. *This system is the official state automated system.*

"Child protective services" means the identification, receipt and immediate ~~investigation of response to~~ complaints and reports of alleged child abuse and/or neglect for children under 18 years of age. It also includes assessment, and arranging for and providing necessary protective and rehabilitative services for a child and his family when the child has been found to have been abused or neglected or is at risk of being abused or neglected.

"Child protective services worker" means one who is qualified by virtue of education, training and supervision and is employed by the local department to respond to child protective services complaints and reports of alleged child abuse and/or neglect.

"Chronically and irreversibly comatose" means a condition caused by injury, disease or illness in which a patient has suffered a loss of consciousness with no behavioral evidence of self-awareness or awareness of surroundings in a learned manner other than reflexive activity of muscles and nerves for low-level conditioned response and from which to a reasonable degree of medical probability there can be no recovery.

"Collateral" means a person whose personal or professional knowledge may help confirm or rebut the allegations of child abuse and/or neglect or whose involvement may help ensure the safety of the child.

"Complaint" means any information or allegation of child abuse and/or neglect made orally or in writing pursuant to § ~~63.1-248.2:5~~ 63.1-248.2 of the Code of Virginia.

"Consultation" means the process by which the alleged abuser and/or neglector may request an informal meeting to discuss the investigative findings with the local department prior to the local department rendering a founded disposition of abuse and/or neglect against that person pursuant to § 63.1-248.6:1 A of the Code of Virginia.

"Controlled substance" means a drug, substance or marijuana as defined in § 18.2-247 of the Code of Virginia including those terms as they are used or defined in the Drug Control Act, Chapter 34 (§ 54.1-3400 et seq.) of Title 54.1 of the Code of Virginia. The term does not include alcoholic beverages or tobacco as those terms are defined or used in Title 3.1 or Title 4.1 of the Code of Virginia.

"Department" means the Virginia Department of Social Services.

"Differential response system" means that local departments of social services may respond to valid reports or complaints of child abuse or neglect by conducting either a family assessment or an investigation.

"Disposition" means the determination of whether or not child abuse and/or neglect has occurred.

"Documentation" means information and materials, written or otherwise, concerning allegations, facts and evidence.

"Family Advocacy Program representative" means the professional employed by the United States Armed Forces who has responsibility for the program designed to address prevention, identification, evaluation, treatment, rehabilitation, follow-up and reporting of family violence, pursuant to 22 VAC 40-720-20.

"Family assessment" means the collection of information necessary to determine:

1. The immediate safety needs of the child;
2. The protective and rehabilitative services needs of the child and family that will deter abuse or neglect;
3. Risk of future harm to the child; and
4. Alternative plans for the child's safety if protective and rehabilitative services are indicated and the family is unable or unwilling to participate in services. These arrangements may be made in consultation with the caretaker(s) of the child.

"First source" means any direct evidence establishing or helping to establish the existence or nonexistence of a fact. Indirect evidence and anonymous complaints do not constitute first source evidence.

"Founded" means that a review of the facts shows by a preponderance of the evidence that child abuse and/or neglect has occurred. A determination that a case is founded shall be based primarily on first source evidence; in no instance shall a determination that a case is founded be based solely on indirect evidence or an anonymous complaint.

"He" means he or she.

"His" means his or her.

"Identifying information" means name, social security number, address, race, sex, and date of birth.

"Indirect evidence" means any statement made outside the presence of the child protective services worker and relayed to the child protective services worker as proof of the contents of the statement.

"Investigation" means the ~~formal collection of information gathering process utilized by the local department in determining whether or not child abuse or neglect has occurred.~~ to determine:

1. The immediate safety needs of the child;
2. The protective and rehabilitative services needs of the child and family that will deter abuse or neglect;
3. Risk of future harm to the child;
4. Alternative plans for the child's safety if protective and rehabilitative services are indicated and the family is unable or unwilling to participate in services;
5. Whether or not abuse or neglect has occurred;
6. If abuse or neglect has occurred, who abused or neglected the child; and
7. A finding of either founded or unfounded based on the facts collected during the investigation.

"Investigative narrative" means the written account of the investigation contained in the child protective services case record.

"Legitimate interest" means a lawful, demonstrated privilege to access the information as defined in § 63.1-209 of the Code of Virginia.

"Licensed substance abuse treatment practitioner" means a person who (i) is trained in and engages in the practice of substance abuse treatment with individuals or groups of individuals suffering from the effects of substance abuse or dependence, and in the prevention of substance abuse or dependence and (ii) is licensed to provide advanced substance abuse treatment and independent, direct and unsupervised treatment to such individuals or groups of individuals, and to plan, evaluate, supervise, and direct substance abuse treatment provided by others.

"Local department" means the city or county local agency of social services or department of public welfare in the Commonwealth of Virginia responsible for conducting investigations of child abuse and/or neglect complaints or reports pursuant to § 63.1-248.6 of the Code of Virginia.

"Local department of jurisdiction" means the local department in the city or county in Virginia where the alleged victim child resides or in which the alleged abuse and/or neglect is believed to have occurred. If neither of these is known, then the local department of jurisdiction shall be the local department in the county or city where the abuse and/or neglect was discovered.

"Mandated reporters" means those persons who are required to report suspicions of child abuse and/or neglect pursuant to § 63.1-248.3 of the Code of Virginia.

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"Monitoring" means contacts with the child, family and collaterals which provide information about the child's safety and the family's compliance with the service plan.

"Multidisciplinary teams" means any organized group of individuals representing, but not limited to, medical, mental health, social work, education, legal and law enforcement, which will assist local departments in the protection and prevention of child abuse and neglect pursuant to § 63.1-248.6 F K of the Code of Virginia. Citizen representatives may also be included.

"Notification" means informing designated and appropriate individuals of the local department's actions and the individual's rights.

"Preponderance of evidence" means the evidence as a whole shows that the facts are more probable and credible than not. It is evidence which is of greater weight or more convincing than the evidence offered in opposition.

"Purge" means to delete or destroy any reference data and materials specific to subject identification contained in records maintained by the department and the local department pursuant to §§ 63.1-248.5:1 and 63.1-248.5:1.01 of the Code of Virginia.

"Reasonable diligence" means the exercise of justifiable and appropriate persistent effort.

"Report" means either a complaint as defined in this section or an official document on which information is given concerning abuse and neglect ~~and which~~. A *report* is required to be made by persons designated herein and by local departments in those situations in which ~~investigation of a response to a complaint~~ from the general public reveals suspected child abuse and/or neglect pursuant to subdivision 5 of the definition of abused or neglected child in § 63.1-248.2 of the Code of Virginia.

"Safety plan" means an immediate course of action designed to protect a child from abuse or neglect.

"Service plan" means a plan of action to address the service needs of a child and/or his family in order to protect a child and his siblings, to prevent future abuse and neglect, and to preserve the family life of the parents and children whenever possible.

"State automated system" means the *"child abuse and neglect information system"* as previously defined.

"Substance abuse counseling or treatment services" are services provided to individuals for the prevention, diagnosis, treatment, or palliation of chemical dependency, which may include attendant medical and psychiatric complications of chemical dependency.

"Terminal condition" means a condition caused by injury, disease or illness from which to a reasonable degree of medical probability a patient cannot recover and (i) the patient's death is imminent or (ii) the patient is chronically and irreversibly comatose.

"Unfounded" means that a review of the facts does not show by a preponderance of the evidence that child abuse or neglect occurred.

"Valid report or complaint" means the local department of social services has evaluated the information and allegations of the report or complaint and determined that the local department shall conduct an investigation or family assessment because the following elements are present:

1. The alleged victim child or children are under the age of 18 at the time of the complaint or report;
2. The alleged abuser is the alleged victim child's parent or other caretaker;
3. The local department receiving the complaint or report is a local department of jurisdiction; and
4. The circumstances described allege suspected child abuse or neglect.

"Withholding of medically indicated treatment" means the failure to respond to the infant's life-threatening condition by providing treatment (including appropriate nutrition, hydration, and medication) which in the treating physician's or physicians' reasonable medical judgment will most likely be effective in ameliorating or correcting all such conditions.

22 VAC 40-705-30. Types of abuse and neglect.

A. Physical abuse occurs when a caretaker creates or inflicts, threatens to create or inflict, or allows to be created or inflicted upon a child a physical injury by other than accidental means or creates a substantial risk of death, disfigurement, or impairment of bodily functions.

B. Physical neglect occurs when there is the failure to provide food, clothing, shelter, or supervision for a child to the extent that the child's health or safety is endangered. This also includes abandonment and situations where the parent's or caretaker's own incapacitating behavior or absence prevents or severely limits the performing of child caring tasks pursuant to § 63.1-248.2 of the Code of Virginia. In situations where the neglect is the result of family poverty and there are no outside resources available to the family, the parent or caretaker shall not be determined to have neglected the child; however, the local department may provide appropriate services to the family.

1. Physical neglect may include multiple occurrences or a one-time critical or severe event that results in a threat to health or safety.
2. Physical neglect may include failure to thrive.

a. Failure to thrive occurs as a syndrome of infancy and early childhood which is characterized by growth failure, signs of severe malnutrition, and variable degrees of developmental retardation.

b. Failure to thrive can only be diagnosed by a physician and is caused by nonorganic factors.

C. Medical neglect occurs when there is the failure by the caretaker to obtain or follow through with a complete regimen of medical, mental or dental care for a condition which if untreated could result in illness or developmental delays pursuant to § 63.1-248.2 of the Code of Virginia. Medical neglect also includes withholding of medically indicated treatment.

1. A child who, in good faith, is under treatment solely by spiritual means through prayer in accordance with the tenets and practices of a recognized church or religious denomination pursuant to § 63.1-248.2 of the Code of Virginia shall not for that reason alone be considered a neglected child.

2. For the purposes of this regulation, "withholding of medically indicated treatment" does not include the failure to provide treatment (other than appropriate nutrition, hydration, or medication) to an infant when in the treating physician's or physicians' reasonable medical judgment:

- a. The infant is chronically and irreversibly comatose;
- b. The infant has a terminal condition and the provision of such treatment would:

- (1) Merely prolong dying;

- (2) Not be effective in ameliorating or correcting all of the infant's life-threatening conditions; ~~or~~

- (3) Otherwise be futile in terms of the survival of the infant; or

- ~~c. The infant has a terminal condition and the provision of such treatment would~~ (4) Be virtually futile in terms of the survival of the infant and the treatment itself under such circumstances would be inhumane.

D. Mental abuse or neglect occurs when a caretaker creates or inflicts, threatens to create or inflict, or allows to be created or inflicted upon a child a mental injury by other than accidental means or creates a substantial risk of impairment of mental functions.

Mental abuse or neglect may include failure to thrive.

1. Failure to thrive occurs as a syndrome of infancy and early childhood which is characterized by growth failure, signs of severe malnutrition, and variable degrees of developmental retardation.

2. Failure to thrive can only be diagnosed by a physician and is caused by nonorganic factors.

E. Sexual abuse occurs when there is any act of sexual exploitation or any sexual act upon a child in violation of the law which is committed or allowed to be committed by the child's parents or other persons responsible for the care of the child pursuant to § 63.1-248.2 of the Code of Virginia.

22 VAC 40-705-40. Complaints and reports of suspected child abuse and/or neglect.

A. Persons who are mandated to report are those individuals defined in § 63.1-248.3 of the Code of Virginia.

1. Mandated reporters shall report immediately any suspected abuse or neglect that they learn of in their professional capacity.

2. *Mandated reporters shall disclose all information that is the basis for the suspicion of child abuse or neglect and shall make available, upon request, to the local department any records and reports that document the basis for the complaint and/or report.*

3. *A mandated reporter's failure to report within 72 hours of the first suspicion of child abuse or neglect shall result in a fine.*

~~2-~~ 4. Pursuant to § 63.1-248.3 A1 of the Code of Virginia, certain specified facts indicating that a newborn infant may have been exposed to controlled substances prior to birth are sufficient to suspect that a child is abused or neglected. A diagnosis of fetal alcohol syndrome is also sufficient. Any report made pursuant to § 63.1-248.3 A1 of the Code of Virginia constitutes a valid report of abuse or neglect and requires a child protective services investigation, unless the mother sought treatment or counseling as required in this section and pursuant to § 63.1-248.6 E 2 of the Code of Virginia.

a. The attending physician may designate a hospital staff person to make the report to the local department on behalf of the attending physician. That hospital staff person may include a nurse or hospital social worker.

b. Pursuant to § 63.1-248.3 B of the Code of Virginia, whenever a physician makes a finding pursuant to § 63.1-248.3 A1 of the Code of Virginia, then the physician or his designee must make a report to child protective services immediately. Pursuant to § 63.1-248.3 B of the Code of Virginia, a physician who fails to make a report pursuant to § 63.1-248.3 A1 of the Code of Virginia is subject to a fine.

c. When a report or complaint alleging abuse or neglect is made pursuant to § 63.1-248.3 A1 of the Code of Virginia, then the local department must immediately assess the infant's circumstances and any threat to the infant's health and safety. Pursuant to 22 VAC 40-705-110 A, the local department must conduct an initial assessment.

d. When a report or complaint alleging abuse or neglect is made pursuant to § 63.1-248.3 A1 of the Code of Virginia, then the local department must immediately determine whether to petition a juvenile and domestic relations district court for any necessary services or court orders needed to ensure the safety and health of the infant.

e. Within the first 14 days of receipt of a report made pursuant to § 63.1-248.3 A1 of the Code of Virginia, the local department shall invalidate the complaint if the following two conditions are met: (i) the mother of the infant sought substance abuse counseling or treatment during her pregnancy prior to the infant's birth and (ii) there is no evidence of child abuse and/or neglect by the mother after the infant's birth.

(1) The local department must notify the mother immediately upon receipt of a complaint made pursuant to § 63.1-248.3 A1 of the Code of Virginia. This notification must include a statement informing the mother that, if the mother fails to present evidence within 14 days of receipt of the complaint that she sought substance abuse counseling/treatment during the pregnancy, the report will be accepted as valid and an investigation initiated.

(2) If the mother sought counseling or treatment but did not receive such services, then the local department

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must determine whether the mother made a substantive effort to receive substance abuse treatment before the child's birth. If the mother made a substantive effort to receive treatment or counseling prior to the child's birth, but did not receive such services due to no fault of her own, then the local department should invalidate the complaint or report.

(3) If the mother sought or received substance abuse counseling or treatment, but there is evidence, other than exposure to a controlled substance, that the child may be abused or neglected, then the local department may initiate the investigation.

f. Substance abuse counseling or treatment includes, but is not limited to, education about the impact of alcohol, controlled substances and other drugs on the fetus and on the maternal relationship; education about relapse prevention to recognize personal and environmental cues which may trigger a return to the use of alcohol or other drugs.

g. The substance abuse counseling or treatment should attempt to serve the purposes of improving the pregnancy outcome, treating the substance abuse disorder, strengthening the maternal relationship with existing children and the infant, and achieving and maintaining a sober and drug-free lifestyle.

h. The substance abuse counseling or treatment services must be provided by a professional. Professional substance abuse treatment or counseling may be provided by a certified substance abuse counselor or a licensed substance abuse treatment practitioner.

i. Facts indicating that the infant may have been exposed to controlled substances prior to birth are not sufficient, in and of themselves, to render a founded disposition of abuse or neglect. The local department must establish, by a preponderance of the evidence, that the infant was abused or neglected according to the statutory and regulatory definitions of abuse and neglect.

j. The local department may provide assistance to the mother in locating and receiving substance abuse counseling or treatment.

~~3. Mandated reporters shall disclose all information which is the basis for the suspicion of child abuse or neglect and shall make available, upon request, to the local department any records and reports which document the basis for the complaint and/or report.~~

~~4. A mandated reporter's failure to report within 72 hours of the first suspicion of child abuse or neglect shall result in a fine.~~

B. Persons who may report child abuse and/or neglect include any individual who suspects that a child is being abused and/or neglected pursuant to § 63.1-248.4 of the Code of Virginia.

C. Complaints and reports of child abuse and/or neglect may be made anonymously. An anonymous complaint, standing alone, shall not meet the preponderance of evidence standard necessary to support a founded determination.

D. Any person making a complaint and/or report of child abuse and/or neglect shall be immune from any civil or criminal liability in connection therewith, unless the court decides that such person acted in bad faith or with malicious intent pursuant to § 63.1-248.5 of the Code of Virginia.

E. When the identity of the reporter is known to the department or local department, these agencies shall make every effort to protect the reporter's identity.

F. If a person suspects that he is the subject of a report or complaint of child abuse and/or neglect made in bad faith or with malicious intent, that person may petition the court for access to the record including the identity of the reporter or complainant pursuant to § 63.1-248.5:1 of the Code of Virginia.

G. Any person age 14 years or older who makes or causes to be made a knowingly false complaint or report of child abuse and/or neglect and is convicted shall be guilty of a Class 4 1 misdemeanor for a first offense pursuant to § 63.1-248.5:1.01 of the Code of Virginia.

1. A subsequent conviction results in a Class 2 ~~misdemeanor~~ 6 felony.

2. Upon receipt of notification of such conviction, the department will retain a list of convicted reporters.

3. The subject of the records may have the records purged upon presentation of proof of such conviction.

H. To make a complaint or report of child abuse and/or neglect, a person may telephone the department's toll-free child abuse and neglect hotline or contact a local department of jurisdiction pursuant to § 63.1-248.4 of the Code of Virginia.

1. The local department of jurisdiction that first receives a complaint or report of child abuse and/or neglect shall assume responsibility to ensure that ~~the complaint or report is investigated~~ a family assessment or an investigation is conducted.

2. A local department may ask another local department ~~which~~ that is a local department of jurisdiction to assist in conducting the family assessment or investigation. If assistance is requested, the local department shall comply.

3. A local department may ask another local department through a cooperative agreement to assist in conducting the family assessment or investigation.

4. If a local department employee is suspected of abusing and/or neglecting a child, the complaint or report of child abuse and/or neglect shall be made to the juvenile and domestic relations district court of the county or city where the alleged abuse and/or neglect was discovered. The judge ~~may~~ shall assign the report for investigation to the ~~court services unit or~~ to a local department that is not the employer of the subject of the report pursuant to §§ 63.1-248.3 and 63.1-248.4 of the Code of Virginia. ~~The judge may consult with the department in selecting a local department to respond.~~

22 VAC 40-705-50. Actions to be taken upon receipt of a complaint or report.

A. All complaints and reports of suspected child abuse and/or neglect shall be recorded in ~~writing on the intake document the child abuse and neglect information system and either screened out or determined valid within 14 days of receipt.~~ A record of all reports and complaints made to a local department or to the department, regardless of whether the report or complaint was found to be a valid complaint of abuse and/or neglect, shall be retained for one year from the date of the complaint.

B. ~~In all valid complaints or reports of child abuse and/or neglect shall be investigated the local department of social services shall determine whether to conduct an investigation or a family assessment.~~ A valid complaint or report is one in which:

1. The alleged victim child or children are under the age of 18 at the time of the complaint and/or report;
2. The alleged abuser is the alleged victim child's parent or other caretaker;
3. The local department receiving the complaint or report is a local department of jurisdiction; and
4. The circumstances described allege suspected child abuse and/or neglect.

C. The local department shall not ~~conduct a family assessment or~~ investigate complaints or reports of child abuse and/or neglect that fail to meet all of the criteria in subsection B of this section.

D. The local department shall report certain cases of suspected child abuse or neglect to the local attorney for the Commonwealth and the local law-enforcement agency pursuant to § 63.1-248.6 E & of the Code of Virginia.

E. Pursuant to § 63.1-248.6 L of the Code of Virginia, local departments shall develop, where practical, memoranda of understanding for responding to reports of child abuse and neglect with local law enforcement and the local office of the commonwealth's attorney.

~~E.~~ F. The local department shall report to the following when the death of a child is involved:

1. When abuse and/or neglect is suspected in any case involving the death of a child, the local department shall report the case immediately to the regional medical examiner pursuant to § 63.1-248.6 ~~E-9~~ F of the Code of Virginia.
2. When abuse and/or neglect is suspected in any case involving the death of a child, the local department shall report the case immediately to the attorney for the Commonwealth and the local law-enforcement agency pursuant to § 63.1-248.6 ~~E-5~~ of the Code of Virginia.
3. The local department shall contact the department immediately upon receiving a complaint involving the death of a child and at the conclusion of the investigation.
4. *The department shall immediately, upon receipt of information, report on all child fatalities to the state board in*

a manner consistent with department policy and procedures approved by the board. At a minimum, the report shall contain information regarding any prior statewide child protective services involvement of the family, alleged perpetrator, or victim.

~~F.~~ G. Valid complaints or reports ~~which meet the criteria for investigation~~ shall be screened for high priority based on the following:

1. The immediate danger to the child;
2. The severity of the type of abuse or neglect alleged;
3. The age of the child;
4. The circumstances surrounding the alleged abuse or neglect;
5. The physical and mental condition of the child; and
6. Reports made by mandated reporters.

~~G.~~ H. The local department shall initiate an immediate ~~investigation response.~~ *The response shall be a family assessment or an investigation. Any valid report may be investigated, but in accordance with § 63.1-248.6:02 B of the Code of Virginia, those cases shall be investigated that involve: (i) sexual abuse, (ii) a child fatality, (iii) abuse or neglect resulting in a serious injury as defined in § 18.2-371.1 of the Code of Virginia, (iv) a child having been taken into the custody of the local department of social services, or (v) a caretaker at a state-licensed child day care center, religiously exempt child day center, regulated family day home, private or public school, or hospital or any institution.*

1. The purpose of an investigation is to collect the information necessary to determine or assess the following:

- a. Immediate safety needs of the child;
- b. Whether or not abuse or neglect has occurred;
- c. Who abused or neglected the child;
- d. To what extent the child is at risk of future harm, either immediate or longer term;
- e. What types of services can meet the needs of this child or family; and
- f. If services are indicated and the family appears to be unable or unwilling to participate in services, what alternate plans will provide for the child's safety.

2. *The purpose of a family assessment is to engage the family in a process to collect the information necessary to determine or assess the following:*

- a. *Immediate safety needs of the child;*
- b. *The extent to which the child is at risk of future harm, either immediate or longer term;*
- c. *The types of services that can meet the needs of this child or family; and*
- d. *If services are indicated and the family appears to be unable or unwilling to participate in services, the plans that will be developed in consultation with the family to*

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provide for the child's safety. These arrangements may be made in consultation with the caretaker(s) of the child.

~~2-~~ 3. The local department shall use reasonable diligence to locate any child for whom a report or complaint of suspected child abuse and/or neglect has been received and ~~is under investigation~~ *determined valid* or persons who are the subject of a *valid* report ~~that is under investigation~~ if the whereabouts of such persons are unknown to the local department pursuant to § 63.1-248.6 ~~E-49~~ G of the Code of Virginia.

~~3-~~ 4. The local department shall document its attempts to locate the child and family.

4. 5. In the event the alleged victim child or children cannot be found, *the time the child cannot be found shall not be computed as part of the 45-60-day time frame to complete the investigation, pursuant to subdivision 5 of § 63.1-248.6* ~~E-7~~ 63.1-248.6:01 of the Code of Virginia, ~~is stayed.~~

22 VAC 40-705-60. Authorities of local departments.

When ~~conducting investigations~~ *responding to valid complaints or reports* local departments have the following authorities:

1. To talk to any child suspected of being abused and/or neglected, or child's siblings, without the consent of and outside the presence of the parent or other caretaker, as set forth by § 63.1-248.10 of the Code of Virginia.

2. To take or arrange for photographs and x-rays of a child who is the subject of a complaint without the consent of and outside the presence of the parent or other caretaker, as set forth in § 63.1-248.13 of the Code of Virginia.

3. To take a child into custody on an emergency removal for up to 72-96 hours under such circumstances as set forth in § 63.1-248.9 of the Code of Virginia.

a. A child protective services (CPS) worker planning to take a child into 72-96-hour emergency custody shall first consult with a supervisor. However, this requirement shall not delay action on the CPS worker's part if a supervisor cannot be contacted and the situation requires immediate action.

b. When circumstances warrant that a child be taken into emergency custody during a family assessment, the report shall be reassigned immediately to an investigation.

~~b-~~ c. Any person who takes a child into custody pursuant to § 63.1-248.9 of the Code of Virginia shall be immune from any civil or criminal liability in connection therewith, unless it is proven that such person acted in bad faith or with malicious intent.

~~c-~~ d. The local department shall have the authority to have a complete medical examination made of the child including a written medical report and, when appropriate, photographs and x-rays pursuant to § 63.1-248.13 of the Code of Virginia.

~~d-~~ e. When a child in 72-96-hour custody is in need of immediate medical or surgical treatment, the local director

of social services or his designee(s) may consent to such treatment when the parent does not provide consent and a court order is not immediately obtainable.

~~e-~~ f. When a child is not in the local department's custody, the local department cannot consent to medical or surgical treatment of the child.

22 VAC 40-705-70. Collection of evidence information.

A. When conducting an investigation the local department shall seek first-source information about the allegation of child abuse and/or neglect. When applicable, the local department shall include in the case record: police reports; depositions; photographs; physical, medical and psychological reports; and any tape recordings of interviews.

B. When completing a family assessment, the local department shall gather all relevant information in collaboration with the family, to the degree possible, in order to determine the child and family services needs related to current safety or future risk of harm to the child.

C. All information collected must be entered in the state automated system and maintained according to § 63.1-248.5:1 for unfounded investigations or family assessments or according to 22 VAC 40-700-30 for founded investigations. *The automated record entered in the statewide automation system is the official record. When documentation is not available in electronic form, it must be maintained in the hard copy portion of the record. Any hard copy information, including photographs and recordings, shall be noted as an addendum to the official record.*

22 VAC 40-705-80. Family assessment and investigation contacts.

A. *During the course of the family assessment, the child protective services (CPS) worker shall make and record the following contacts and observations.*

1. The child protective services worker shall conduct a face-to-face interview with and observe the alleged victim child and siblings.

2. The child protective services worker shall conduct a face-to-face interview with the alleged victim child's parents or guardians and/or any caretaker named in the report.

3. The child protective services worker shall observe the family environment, contact pertinent collaterals, and review pertinent records in consultation with the family.

B. During the course of the investigation, the child protective services (CPS) worker shall make and record in writing in the ~~investigative narrative~~ *state automated system* the following contacts and observations. When any of these contacts or observations is not made, the CPS worker shall record in writing ~~in the investigative narrative~~ why the specific contact or observation was not made.

1. The child protective services worker shall conduct a face-to-face interview with and observation of the alleged victim child. All interviews with alleged victim children must be audio tape recorded except when the child protective services worker determines that:

- a. The child's safety may be endangered by audio taping;
- b. The age and/or developmental capacity of the child makes audio taping impractical;
- c. A child refuses to participate in the interview if audio taping occurs; or
- d. In the context of a team investigation with law-enforcement personnel, the team or team leader determines that audio taping is not appropriate.

In the case of an interview conducted with a nonverbal child where none of the above exceptions apply, it is appropriate to audio tape record the questions being asked by the child protective services worker and to describe, either verbally or in writing, the child's responses. A child protective services worker shall document in detail in the record and discuss with supervisory personnel the basis for a decision not to audio tape record an interview with the alleged victim child.

A child protective services finding may be based on the written narrative of the child protective services worker in cases where an audio recording is unavailable due to equipment failure or other cause.

2. The child protective services (CPS) worker shall conduct a face-to-face interview with the alleged abuser and/or neglecter.

- a. The CPS worker shall inform the alleged abuser and/or neglecter of his right to tape record any communication pursuant to § 63.1-248.6:2 of the Code of Virginia.
- b. The local department shall provide the necessary equipment in order to tape record the interview and retain a copy of the tape for the record.

3. The child protective services worker shall conduct a face-to-face interview with the alleged victim child's parents or guardians.

4. The child protective services worker shall observe the environment where the alleged victim child lives.

5. The child protective services worker shall observe the site where the alleged incident took place.

6. The child protective services worker shall conduct interviews with collaterals who have pertinent information relevant to the investigation and the safety of the child.

22 VAC 40-705-90. Family assessment and investigative protocol.

A. In conducting a family assessment, the child protective services (CPS) worker may enter the home if permitted to enter by a person who resides in the home. In conducting an investigation, the child protective services (CPS) worker may enter the home if permitted to enter by a person who resides in the home after advising the person who resides in the home that he may refuse to permit entry. Only in those instances where the CPS worker has probable cause to believe that the life or health of the child would be seriously endangered within the time it would take to obtain a court order or the assistance of a law-enforcement officer, may a CPS worker enter the home without permission. A child protective services worker shall document in detail in the record and discuss with

supervisory personnel the basis for the decision to enter the house without permission.

B. Before conducting a family assessment or investigation, the child protective services worker shall explain the responsibilities and authorities of CPS so that the parent or other caretaker can be made aware of the possible benefits and consequences of completing the family assessment or investigation. The explanation must be provided orally and in writing.

B. C. The child protective services worker may transport a child ~~with~~ without parental consent, only when the local department has assumed custody of that child by virtue of 72-96-hour removal authority pursuant to § 63.1-248.9 of the Code of Virginia, by an emergency removal court order pursuant to § 16.1-251 of the Code of Virginia, or by a preliminary removal order pursuant to § 16.1-252 of the Code of Virginia.

C. D. When a child protective services worker has reason to believe that the ~~alleged abuser and/or neglecter~~ caretaker in a valid report of child abuse or neglect is abusing substances and such behavior may be related to the matter being investigated or assessed, the worker may request that person to consent to substance abuse screening or may petition the court to order such screening.

1. Local departments must develop guidelines for such screening.

2. Guidelines may include child protective services worker administration of urine screening.

22 VAC 40-705-110. Assessment Assessments in family assessments and investigations.

A. In both family assessments and investigations the child protective services worker shall conduct an initial assessment of the child's circumstances and threat of danger or harm, and where appropriate shall make a safety plan to provide for the protection of the child.

~~B. The child protective services worker shall make a dispositional assessment after collecting and synthesizing information about the alleged abuse or neglect.~~

C. B. In all founded cases and in completed family assessments, the child protective services worker shall make a risk assessment to determine whether or not the child is in jeopardy of future abuse and/or neglect and whether or not intervention is necessary to protect the child.

C. In investigations, the child protective services worker shall make a dispositional assessment after collecting and synthesizing information about the alleged abuse or neglect.

22 VAC 40-705-120. Complete the family assessment or investigation.

A. The local department shall promptly notify the alleged abuser and/or neglecter and the alleged victim's parents or guardians of any extension of the deadline for the completion of the family assessment or investigation pursuant to ~~§ 63.1-248.6 E-7~~ 63.1-248.6:02 A 3 or subdivision 5 of § 63.1-248.6:01 of the Code of Virginia. The child protective services

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worker shall document the notifications and the reason for the need for additional time in the case record.

B. At the completion of the family assessment, the subject of the report shall be notified orally and in writing of the results of the assessment.

C. The subject of the report shall be notified immediately if during the course of completing the family assessment the situation is reassessed and determined to meet the requirements, as specified in § 63.1-248.6:02 B of the Code of Virginia, to be investigated.

~~B. D.~~ When completing an investigation, prior to rendering a founded disposition concerning a complaint of child abuse and/or neglect, the local department shall provide the alleged abuser and/or neglecter with written notice of the options available to him pursuant to subdivisions ~~E~~ 1 and ~~E~~ 2 of this section. Whenever a criminal charge is also filed against the alleged abuser for the same conduct involving the same victim child as investigated by the local department, a predispositional conference is not an option.

~~E.~~ Otherwise, an alleged abuser and/or neglecter involved in an investigation may elect to proceed under either subdivision 1 or 2 of this subsection. If the alleged abuser and/or neglecter does not advise the local department of his decision within 10 days of receipt of the written notice, he will be deemed to have elected to proceed under subdivision 2 of this subsection.

1. Predispositional consultation. The purpose of the predispositional consultation shall be to allow a person suspected of committing child abuse and/or neglect the opportunity to meet with the local department conducting the investigation and discuss the local department's investigation findings prior to the disposition.

a. In order to participate in a predispositional consultation, the alleged abuser and/or neglecter must agree to waive the 45-60-day time frame to conduct the investigation, not to exceed an additional 30 working days. Further, the alleged abuser and/or neglecter must agree to waive his right to a local conference pursuant to § 63.1-248.6:1 of the Code of Virginia.

b. The alleged abuser and/or neglecter shall be afforded the opportunity to informally present testimony, witnesses or documentation to representatives of the local department.

c. The local department shall consider any evidence presented by the alleged abuser and/or neglecter prior to rendering a disposition.

d. Should the local department render a founded disposition following a predispositional consultation, the local department shall notify the abuser and/or neglecter, in writing, of that person's right to appeal the local department's finding to the Commissioner of the Virginia Department of Social Services pursuant to 22 VAC 40-705-140 and § 63.1-248.6:1 A of the Code of Virginia.

2. Local conference.

a. If the alleged abuser and/or neglecter elects not to participate in a predispositional consultation or does not advise the local department of his decision within 10 days of receiving written notification of the local department's findings pursuant to subsection ~~B~~ D of this section, he will be deemed to have elected to proceed under this subdivision 2. If the alleged abuser and/or neglecter is found to have committed abuse or neglect, that alleged abuser and/or neglecter may, within 30 days of being notified of that determination, submit a written request for an amendment of the determination and the local department's related records pursuant to § 63.1-248.6:1 A of the Code of Virginia. The local department shall conduct an informal conference in an effort to examine the local department's disposition and reasons for it and consider additional information about the investigation and disposition presented by the alleged abuser and/or neglecter.

b. The local conference shall be conducted in accordance with 22 VAC 40-705-190.

22 VAC 40-705-130. Report findings family assessment or investigation conclusions.

A. Pursuant to § 63.1-248.5:1 of the Code of Virginia, the local department shall report all unfounded case dispositions to the child abuse and neglect information system (~~CANIS~~) when disposition is made.

1. The department shall retain unfounded complaints and/or reports in ~~CANIS~~ the child abuse and neglect information system to provide local departments with information regarding prior investigations.

2. This record shall be kept separate from the Central Registry and accessible only to the department and to local departments.

3. The record of the unfounded case or family assessment shall be purged one year after the date of the complaint or report if there are no subsequent founded or unfounded complaints and/or reports regarding the individual against whom allegations of abuse and/or neglect were made or regarding the same child in that one year.

4. If the individual against whom allegations of abuse and/or neglect were made or if the same child is involved in subsequent complaints and/or reports, the information from all complaints and/or reports shall be maintained until the last purge date has been reached.

5. The individual against whom allegations of abuse and/or neglect were made may request in writing that the local department retain the record for an additional period of up to two years.

6. The individual against whom allegations of abuse and/or neglect were made may request in writing that both the local department and the department shall immediately purge the record after a court rules that the report was made in bad faith or with malicious intent pursuant to § 63.1-248.5:1 of the Code of Virginia.

B. The local department shall report all founded case dispositions to the child abuse and neglect information system

for inclusion in the Central Registry pursuant to *subdivision 5 of § 63.1-248.6 E-7* 63.1-248.6:01 of the Code of Virginia and 22 VAC 40-700-30. Identifying information about the abuser and/or neglector and the victim child or children reported include demographic information, type of abuse or neglect, and date of the complaint. The identifying information shall be retained based on the determined level of severity of the abuse or neglect pursuant to the regulation dealing with retention in the Central Registry, 22 VAC 40-700-30.

22 VAC 40-705-140. Notification of findings.

A. Upon completion of the investigation the local child protective services worker shall make notifications as provided in this section.

B. Individual against whom allegations of abuse and/or neglect were made.

1. When the disposition is unfounded, the child protective services worker shall inform the individual against whom allegations of abuse and/or neglect were made of this finding. This notification shall be in writing with a copy to be maintained in the case record. The individual against whom allegations of abuse and/or neglect were made shall be informed that he may have access to the case record and that the case record shall be retained by the local department for one year unless requested in writing by such individual that the local department retain the record for up to an additional two years.

a. If the individual against whom allegations of abuse and/or neglect were made or the subject child is involved in subsequent complaints, the information from all complaints shall be retained until the last purge date has been reached.

b. The local worker shall notify the individual against whom allegations of abuse and/or neglect were made of the procedures set forth in § 63.1-248.5:1 of the Code of Virginia.

c. When an unfounded investigation involves a child death, the child protective services worker shall inform the individual against whom allegations of abuse and/or neglect were made that the case record will be retained for the longer of 12 months or until the State Child Fatality Review Team has completed its review of the case pursuant to § 32.1-283.1 D of the Code of Virginia.

2. Pursuant to 22 VAC 40-705-120 and 22 VAC 40-705-190, when a predispositional consultation results with the local department rendering a founded disposition of abuse and/or neglect, the child protective services worker shall notify the abuser and/or neglector by letter, with a copy included in the case record. The letter shall include:

- a. A clear statement that they are the abuser and/or neglector;
- b. The type of abuse and/or neglect;
- c. The disposition, level and retention time;
- d. The name of the victim child or children; and

e. A statement informing the abuser of the right to appeal to the commissioner of the department and to have access to the case record.

3. Pursuant to 22 VAC 40-705-120 and 22 VAC 40-705-190, if a predispositional consultation did not occur and the local department renders a founded disposition of abuse and/or neglect, the child protective services worker shall notify the abuser and/or neglector by letter, with a copy included in the case record. The letter shall include:

- a. A clear statement that they are the abuser and/or neglector;
- b. The type of abuse and/or neglect;
- c. The disposition, level and retention time;
- d. The name of the victim child or children; and
- e. A statement informing the abuser and/or neglector of his right to request the local department for a local conference and to have access to the case record.

4. When the abuser and/or neglector in a founded complaint is a foster parent of the victim child, the local department shall place a copy of this notification letter in the child's foster care record and in the foster home provider record.

5. No disposition of founded or unfounded shall be made in a family assessment. At the completion of the family assessment the subject of the report shall be notified orally and in writing of the results of the assessment.

C. Subject child's parents or guardian.

1. When the disposition is unfounded, the child protective services worker shall inform the parents or guardian of the subject child in writing, when they are not the individuals against whom allegations of child abuse and/or neglect were made, that the complaint involving their child was determined to be unfounded and the length of time the child's name and information about the case will be maintained. The child protective services worker shall file a copy in the case record.

2. When the disposition is founded, the child protective services worker shall inform the parents or guardian of the child in writing, when they are not the abuser and/or neglector, that the complaint involving their child was determined to be founded and the length of time the child's name and information about the case will be retained in the Central Registry. The child protective services worker shall file a copy in the case record.

3. When the founded case of abuse or neglect does not name the parents or guardians of the child as the abuser or neglector and when the abuse or neglect occurred in a licensed or unlicensed day care center, a regulated family day home, a private or public school, a child-caring institution or a residential facility for juveniles, the parent or guardian must be consulted and must give permission for the child's name to be entered into the central registry pursuant to § 63.1-248.8 of the Code of Virginia.

D. Complainant.

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1. When an unfounded disposition is made, the child protective services worker shall notify the complainant, when known, in writing that the complaint was investigated and determined to be unfounded. The worker shall file a copy in the case record.

2. When a founded disposition is made, the child protective services worker shall notify the complainant, when known, in writing that the complaint was investigated and necessary action was taken. The local worker shall file a copy in the case record.

3. *When a family assessment is completed, the child protective services worker shall notify the complainant, when known, that the complaint was assessed and necessary action taken.*

E. Family Advocacy Program. When a founded disposition is made, the child protective services worker shall notify the Family Advocacy Program representative in writing as set forth in 22 VAC 40-720-20.

22 VAC 40-705-150. Services.

~~A. When abuse or neglect is found~~ *At the completion of a family assessment or investigation, the local department shall consult with the family to provide or arrange for necessary protective and rehabilitative services to be provided to the child and his family pursuant to subdivision 3 of § 63.1-248.6 E-3 63.1-248.6:01 or 63.1-248.6:02 A of the Code of Virginia.*

~~B. Families may decline services offered as a result of family assessment. If the family declines services, the case shall be closed unless there is an existing court order or the local department determines that sufficient cause exists due to threat of harm or actual harm to the child to redetermine the case as one that needs to be investigated or brought to the attention of the court. In no instance shall these actions be taken solely because the family declines services.~~

~~C. At the completion of a family assessment or investigation, local departments of social services may petition the court for services deemed necessary.~~

~~B. D.~~ Protective services also includes preventive services to children about whom no formal complaint of abuse or neglect has been made, but for whom potential harm or threat of harm exists, to be consistent with §§ 16.1-251, 16.1-252, 16.1-279.1, 63.1-248.6 F K, and 63.1-248.7 of the Code of Virginia.

~~G. E.~~ Local departments shall support the establishment and functioning of multidisciplinary teams pursuant to § 63.1-248.6 F K of the Code of Virginia.

~~D. F.~~ The local department must use reasonable diligence to locate any child for whom a founded disposition of abuse or neglect has been made and a child protective services case has been opened pursuant to § 63.1-248.6 E-10, 11 and/or 12 G(i) of the Code of Virginia. The local department shall document its attempts to locate the child and family.

~~E. G.~~ When an abused or neglected child and persons who are the subject of an open child abuse services case have relocated out of the jurisdiction of the local department, the local department shall notify the child protective services

agency in the jurisdiction to which such persons have relocated, whether inside or outside of the Commonwealth of Virginia, and forward to such agency relevant portions of the case records pursuant to § 63.1-248.6 E-44 H of the Code of Virginia.

~~F. H.~~ The receiving local department shall arrange necessary protective and rehabilitative services pursuant to § 63.1-248.6 H of the Code of Virginia.

22 VAC 40-705-160. Releasing information.

A. In the following instances of mandatory disclosure the local department shall release child protective services information. The local department may do so without any written release.

1. Report to attorney for the Commonwealth and law enforcement pursuant to § 63.1-248.6 E 5 of the Code of Virginia.

2. Report to the medical examiner's office pursuant to §§ 32.1-283.1 C and 63.1-248.6 E-9 F of the Code of Virginia.

3. If a court mandates disclosure of information from a child abuse and neglect case record, the local department must comply with the request. The local department may challenge a court action for the disclosure of the case record or any contents thereof. Upon exhausting legal recourse, the local department shall comply with the court order.

4. When a ~~disposition~~ *family assessment or investigation is made completed*, the child protective services worker shall notify the complainant/reporter that either a complaint/report is unfounded or that necessary action is being taken.

5. Any individual, including an individual against whom allegations of child abuse and/or neglect were made, may exercise his Privacy Protection Act (§ 2-1-377 2.2-3800 et seq. of the Code of Virginia) rights to access personal information related to himself which is contained in the case record including, with the individual's notarized consent, a search of the Central Registry pursuant to § 2-1-342 2.2-3704 of the Code of Virginia.

6. When the material requested includes personal information about other individuals, the local department shall be afforded a reasonable time in which to redact those parts of the record relating to other individuals.

7. Pursuant to the Child Abuse Prevention and Treatment Act, as amended (42 USC § 5101 et seq.), and federal regulations (45 CFR Part 1340), the local department shall provide case-specific information about child abuse and neglect reports and investigations to citizen review panels when requested.

8. Pursuant to the Child Abuse Prevention and Treatment Act, as amended (42 USC § 5101 et seq.), the department shall develop guidelines to allow for public disclosure in instances of child fatality or near fatality.

9. An individual's right to access information under the Privacy Protection Act is stayed during criminal prosecution pursuant to § 2-1-384 2.2-3802 of the Code of Virginia.

10. The local department shall disclose and release to the United States Armed Forces Family Advocacy Program child protective services information as required pursuant to 22 VAC 40-720-20.

11. Child protective services shall, on request by the Division of Child Support Enforcement, supply information pursuant to § 63.1-274.6 of the Code of Virginia.

12. The local department shall release child protective services information to a court appointed special advocate pursuant to § ~~9-173.12~~ 9.1-156 A of the Code of Virginia.

13. The local department shall release child protective services information to a court-appointed guardian ad litem pursuant to § 16.1-266 E of the Code of Virginia.

B. The local department may use discretion in disclosing or releasing child protective services case record information, investigative and on-going services to parties having a legitimate interest when the local department deems disclosure to be in the best interest of the child. The local department may disclose such information without a court order and without a written release pursuant to § 63.1-209 A of the Code of Virginia.

C. The local department shall not release the identity of persons reporting incidents of child abuse or neglect, unless court ordered, in accordance with § 63.1-248.6:1 of the Code of Virginia, 42 USC § 5101 et seq., and federal regulations (45 CFR Part 1340).

D. Prior to disclosing information to any individuals or organizations, and to be consistent with § 63.1-209 of the Code of Virginia, pursuant to § 63.1-248 of the Code of Virginia, the local department must be satisfied that:

1. The information will be used only for the purpose for which it is made available;
2. Such purpose shall be related to the goal of child protective or rehabilitative services; and
3. The confidential character of the information will be preserved to the greatest extent possible.

22 VAC 40-705-180. Training.

A. The department shall implement a uniform training plan for child protective services workers. The plan shall establish minimum standards for all child protective services workers in the Commonwealth of Virginia.

B. Workers shall complete skills and policy training specific to child abuse and neglect investigations within the first year of their employment.

C. In order to comply with § 63.1-248.2:1, all local departments must ensure that staff involved in the differential response system attend the training provided by the department. An agency shall become designated as a CPS differential response agency by the department after staff have received the training.

22 VAC 40-705-190. Appeals

A. Appeal is the process by which the abuser and/or neglector may request amendment of the record when the investigation

into the complaint has resulted in a founded disposition of child abuse and/or neglect.

B. If the alleged abuser and/or neglector elects not to participate in a predispositional consultation or does not advise the local department of his decision within 10 days of receiving written notification of the local department's findings pursuant to 22 VAC 40-705-120 B, he will be deemed to have elected to proceed under 22 VAC 40-705-120 C 2.

If the alleged abuser and/or neglector is found to have committed abuse or neglect, that alleged abuser and/or neglector may, within 30 days of being notified of that determination, submit a written request for an amendment of the determination and the local department's related records, pursuant to § 63.1-248.6:1 A of the Code of Virginia. The local department shall conduct an informal conference in an effort to examine the local department's disposition and reasons for it and consider additional information about the investigation and disposition presented by the alleged abuser and/or neglector. The local department shall notify the child abuse and neglect information system (~~CANIS~~) that an appeal is pending.

C. Whenever an appeal is requested and a criminal charge is also filed against the appellant for the same conduct involving the same victim child as investigated by the local department, the appeal process shall be stayed until the criminal prosecution in circuit court is completed pursuant to § 63.1-248.6:1 C of the Code of Virginia. During such stay, the appellant's right of access to the records of the local department regarding the matter being appealed shall also be stayed. Once the criminal prosecution in circuit court has been completed, the local department shall advise the appellant in writing of his right to resume his appeal within the time frames provided by law and regulation pursuant to § 63.1-248.6:1 C of the Code of Virginia.

D. The local department shall conduct an informal, local conference and render a decision on the appellant's request to amend the record within 45 days of receiving the request. If the local department either refuses the appellant's request for amendment of the record as a result of the local conference, or if the local department fails to act within 45 days of receiving such request, the appellant may, within 30 days thereafter and in writing, request the commissioner for an administrative hearing pursuant to § 63.1-248.6:1 A of the Code of Virginia.

E. The appellant may request, in writing, an extension of the 45-day requirement for a specified period of time, not to exceed an additional 60 days. When there is an extension period, the 30-day time frame to request an administrative hearing from the Commissioner of the Department of Social Services shall begin on the termination of the extension period pursuant to § 63.1-248.6:1 A of the Code of Virginia.

F. Upon written request, the local department shall provide the appellant all information used in making its determination. Disclosure of the reporter's name or information which may endanger the well-being of a child shall not be released. The identity of collateral witnesses or any other person shall not be released if disclosure may endanger their life or safety. Information prohibited from being disclosed by state or federal

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law or regulation shall not be released. In case of any information withheld, the appellant shall be advised of the general nature of the information and the reasons, of privacy or otherwise, that it is being withheld, pursuant to § 63.1-248.6:1 A of the Code of Virginia.

G. The director of the local department, or a designee of the director, shall preside over the local conference. With the exception of the director of the local department, no person whose regular duties include substantial involvement with child abuse and neglect cases shall preside over the local conference pursuant to § 63.1-248.6:1 A of the Code of Virginia.

1. The appellant may be represented by counsel pursuant to § 63.1-248.6:1 A of the Code of Virginia.

2. The appellant shall be entitled to present the testimony of witnesses, documents, factual data, arguments or other submissions of proof pursuant to § 63.1-248.6:1 A of the Code of Virginia.

3. The director of the local department, or a designee of the director, shall notify the appellant, in writing, of the results of the local conference within 45 days of receipt of the written request from the appellant unless the time frame has been extended as described in subsection E of this section. The director of the local department, or the designee of the director, shall have the authority to sustain, amend, or reverse the local department's findings. Notification of the results of the local conference shall be mailed, certified with return receipt, to the appellant. The local department shall notify the child abuse and neglect information system (CANIS) of the results of the local conference.

H. If the appellant is unsatisfied with the results of the local conference, the appellant may, within 30 days of receiving notice of the results of the local conference, submit a written request to the commissioner for an administrative hearing pursuant to § 63.1-248.6:1 B of the Code of Virginia.

1. The commissioner shall designate a member of his staff to conduct the proceeding pursuant to § 63.1-248.6:1 B of the Code of Virginia.

2. A hearing officer shall schedule a hearing date within 45 days of the receipt of the appeal request unless there are delays due to subpoena requests, depositions or scheduling problems.

3. After a party's written motion and showing good cause, the hearing officer may issue subpoenas for the production of documents or to compel the attendance of witnesses at the hearing. The victim child and that child's siblings shall not be subpoenaed, deposed or required to testify, pursuant to § 63.1-248.6:1 B of the Code of Virginia.

4. Upon petition, the juvenile and domestic relations district court shall have the power to enforce any subpoena that is not complied with or to review any refusal to issue a subpoena. Such decisions may not be further appealed except as part of a final decision that is subject to judicial review pursuant to § 63.1-248.6:1 B of the Code of Virginia.

5. Upon providing reasonable notice to the other party and the hearing officer, a party may, at his own expense,

depose a nonparty and submit that deposition at, or prior to, the hearing. The victim child and the child's siblings shall not be deposed. The hearing officer is authorized to determine the number of depositions that will be allowed pursuant to § 63.1-248.6:1 B of the Code of Virginia.

6. The local department shall provide the hearing officer a copy of the investigation record prior to the administrative hearing. By making a written request to the local department, the appellant may obtain a copy of the investigation record. The appellant shall be informed of the procedure by which information will be made available or withheld from him.

In any case of information withheld, the appellant shall be advised of the general nature of the information and the reasons that it is being withheld pursuant to § 63.1-248.6:1 B of the Code of Virginia.

7. The appellant and the local department may be represented by counsel at the administrative hearing.

8. The hearing officer shall administer an oath or affirmation to all parties and witnesses planning to testify at the hearing pursuant to § 63.1-248.6:1 B of the Code of Virginia.

9. The local department shall have the burden to show that the preponderance of the evidence supports the founded disposition. The local department shall be entitled to present the testimony of witnesses, documents, factual data, arguments or other submissions of proof.

10. The appellant shall be entitled to present the testimony of witnesses, documents, factual data, arguments or other submissions of proof.

11. The hearing officer may allow either party to submit new or additional evidence at the administrative hearing if it is relevant to the matter being appealed.

12. The hearing officer shall not be bound by the strict rules of evidence. However, the hearing officer shall only consider that evidence, presented by either party, which is substantially credible or reliable.

13. The hearing officer may allow the record to remain open for a specified period of time, not to exceed 14 days, to allow either party to submit additional evidence unavailable for the administrative hearing.

14. In the event that new or additional evidence is presented at the administrative hearing, the hearing officer may remand the case to the local department for reconsideration of the findings. If the local department fails to act within 14 days or fails to amend the findings to the satisfaction of the appellant, then the hearing officer shall render a decision, pursuant to § 63.1-248.6:1 B of the Code of Virginia.

I. Within 60 days of the close of receiving evidence, the hearing officer shall render a written decision. The hearing officer shall have the authority to sustain, amend, or reverse the local department's findings. The written decision of the hearing officer shall state the findings of fact, conclusions based on regulation and policy, and the final disposition. The decision will be sent to the appellant by certified mail, return

receipt requested. Copies of the decision shall be mailed to the appellant's counsel, the local department and the local department's counsel. The hearing officer shall notify the child abuse and neglect information system (CANIS) of the hearing decision. The local department shall notify all other prior recipients of the record of the findings of the hearing officer's decision.

J. The hearing officer shall notify the appellant of the appellant's further right of review in circuit court in the event that the appellant is not satisfied with the written decision of the hearing officer. Appeals are governed by Part 2A of the Rules of the Supreme Court of Virginia. The local department shall have no further right of review pursuant to § 63.1-248.6:1 B of the Code of Virginia.

K. In the event that the hearing officer's decision is appealed to circuit court, the department shall prepare a transcript for that proceeding. That transcript or narrative of the evidence shall be provided to the circuit court along with the complete hearing record. If a court reporter was hired by the appellant, the court reporter shall prepare the transcript and provide the court with a transcript.

VA.R. Doc. No. R02-54; Filed May 1, 2002, 11:52 a.m.

TITLE 24. TRANSPORTATION AND MOTOR VEHICLES

STATE CORPORATION COMMISSION

REGISTRAR'S NOTICE: The State Corporation Commission is exempt from the Administrative Process Act in accordance with § 2.2-4002 A 2 of the Code of Virginia, which exempts courts, any agency of the Supreme Court, and any agency which by the Constitution is expressly granted any of the powers of a court of record.

Title of Regulation: State Corporation Commission Motor Carrier Regulations.

24 VAC 15-100. Single State Insurance Registration Program (REPEAL).

24 VAC 15-110. Rules and Regulations Governing the Supervision, Control and Operation of Common Carriers of Passengers by Motor Vehicle (REPEAL).

24 VAC 15-120. Rules and Regulations Governing the Supervision, Control and Operation of Sight-Seeing Carriers by Motor Vehicle (REPEAL).

24 VAC 15-130. Rules and Regulations Governing the Supervision, Control and Operation of Common Carriers of Property by Motor Vehicle (REPEAL).

24 VAC 15-140. Rules and Regulations Governing the Supervision, Control and Operation of Special or Charter Party Carriers by Motor Vehicle (REPEAL).

24 VAC 15-150. Rules and Regulations Governing the Operation of Motor Vehicles under Lease (REPEAL).

24 VAC 15-160. Rules and Regulations Governing the Supervision, Control and Operation of Household Goods Carriers by Motor Vehicle (REPEAL).

24 VAC 15-170. Rules and Regulations Governing the Supervision, Control and Operation of Petroleum Tank Truck Carriers by Motor Vehicle in Intrastate Commerce (REPEAL).

24 VAC 15-180. Insurance Requirements for Taxicabs (REPEAL).

24 VAC 15-190. Increased Insurance Requirements for Motor Carriers of Passengers (REPEAL).

24 VAC 15-200. Increased Insurance Requirements for Motor Carriers of Property (REPEAL).

24 VAC 15-210. Certificate of Insurance (REPEAL).

Statutory Authority: § 12.1-13 of the Code of Virginia.

Public Hearing Date: N/A -- Public comments may be submitted until June 3, 2002.

Agency Contact: Kara Hart, Attorney, State Corporation Commission, P.O. Box 1197, Richmond, VA 23218, telephone (804) 371-9671, FAX (804) 371-9240, toll free 1-800-552-7945 or e-mail khart@scc.state.va.us.

Summary:

The regulatory action repeals the State Corporation Commission's regulations regarding motor carriers. The repealed regulations are incorporated into the Code of Virginia by Chapter 596 of the 2001 Acts of Assembly. Specific repealed regulations addressed single state insurance registration, common carriers of passengers by motor vehicle, sight-seeing carriers by motor vehicles, common carriers of property by motor vehicle, insurance requirements, household goods carriers, and related issues.

AT RICHMOND, APRIL 17, 2002

COMMONWEALTH OF VIRGINIA, ex rel.

STATE CORPORATION COMMISSION

CASE NO. CLK-2002-00004

Ex Parte: In the matter of
repealing certain regulations
relating to the regulation of
motor carriers

ORDER FOR NOTICE AND COMMENT

As a result of the enactment of Chapter 744 of the 1995 Acts of Assembly ("Chapter 744"), certain regulations issued by the State Corporation Commission ("Commission") require repeal. Chapter 744 transferred the Commission's authority relating to the regulation of motor carriers to the Department of Motor Vehicles ("DMV"). This legislation further provided that all rules, regulations, and orders governing the operations, supervision, and control of motor carriers in effect on July 1, 1995, were to remain in effect until "such time as changed in accordance with law."

In 2000, DMV formed the Motor Carrier Reform Task Force to review Virginia motor carrier statutes, rules, regulations, and orders and to make reform recommendations to the General Assembly. The General Assembly enacted Chapter 596 of the 2001 Acts of Assembly which, among other things, incorporated all of the motor carrier regulations into the Code of Virginia ("Code"). The Commission's motor carrier

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regulations may be repealed as their requirements are now contained in the Code.

The regulations proposed for repeal appear in Attachment 1 hereto [see list of regulations above].

NOW UPON CONSIDERATION of the matter, the Commission is of the opinion and finds that public notice should be given, and that interested persons should be afforded an opportunity to file written comments on the proposed repeal.

Accordingly, IT IS ORDERED THAT:

(1) This matter shall be docketed and assigned Case No. CLK-2002-00004.

(2) A copy of this Order shall forthwith be made available for public review between the hours of 8:15 a.m. and 5:00 p.m., Monday through Friday, at the State Corporation Commission's Document Control Center, located on the first floor of the Tyler Building, 1300 East Main Street, Richmond, Virginia.

(3) The Commission's Division of Information Resources shall forward this Order to the Registrar of Regulations for publication in the *Virginia Register of Regulations*.

(4) On or before June 3, 2002, interested persons wishing to comment on the proposed repeal may file an original and fifteen (15) copies of written comments with Joel H. Peck, Clerk of the Commission, State Corporation Commission, P.O. Box 2118, Richmond, Virginia 23218.

(5) This matter is continued for further orders of the Commission.

AN ATTESTED COPY HEREOF shall be served by the Clerk of the Commission to: Asbury W. Quillian, Commissioner, Department of Motor Vehicles, P.O. Box 27412, Richmond, Virginia 27412; Judy Peterson, Department of Motor Vehicles, P.O. Box 27412, Richmond, Virginia 27412; C. Meade Browder, Jr., Senior Assistant Attorney General, Division of Consumer Counsel, Office of Attorney General, 900 East Main Street, Second Floor, Richmond, Virginia 23219; and the Commission's Office of General Counsel.

VA.R. Doc. No. R02-163; Filed April 24, 2002, 4:07 p.m.

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FINAL REGULATIONS

For information concerning Final Regulations, see Information Page.

Symbol Key

Roman type indicates existing text of regulations. *Italic type* indicates new text. Language which has been stricken indicates text to be deleted. [Bracketed language] indicates a change from the proposed text of the regulation.

TITLE 4. CONSERVATION AND NATURAL RESOURCES

MARINE RESOURCES COMMISSION

Title of Regulation: **4 VAC 20-430. Pertaining to the Marking and Minimum Mesh Size of Gill Nets (amending 4 VAC 20-430-50 and 4 VAC 20-430-60).**

Statutory Authority: §§ 28.201 and 28.2-236 of the Code of Virginia.

Effective Date: May 1, 2002.

Summary:

The amendments extend the time period for marking drift gill nets and the use of mesh drift gill nets of at least two inches, stretched, for the purposes of harvesting river herring.

Agency Contact: Deborah R. Cawthon, Marine Resources Commission, 2600 Washington Avenue, 3rd Floor, Newport News, VA 23607, telephone (757) 247-2248.

4 VAC 20-430-50. Drift gill net fishery exemption.

During the period February 15 through ~~April 30~~ May 31, inclusive, it shall be unlawful for any person to place, set, or fish any drift gill net, in the areas designated below, that is not marked in the following manner:

1. Both end-marker buoys and all floats or buoys between the ends shall be of blaze orange or fluorescent paint color.
2. Areas designated.
 - a. James River. Upstream of the Jamestown Ferry Docking Station.
 - b. Mattaponi and Pamunkey Rivers. Upstream of the Route 33 bridges at West Point.
 - c. Rappahannock River. Upstream of the Route 360 bridge at Tappahannock.

4 VAC 20-430-60. Minimum mesh size.

A. It shall be unlawful for any person to place, set or fish any gill net with a stretched mesh of less than 2-7/8 inches, except as provided in subsections C and D of this section.

B. Mesh measurement is defined as the inside stretched distance between two knots on opposite sides of the same mesh.

C. As provided in § 28.2-305 of the Code of Virginia, mullet gill nets less than 200 yards long shall consist of a stretched mesh not less than two inches stretched measure after having been tarred. Any person utilizing a mullet gill net may not take

or possess quantities of species other than mullet which comprise more than 15% of their total daily catch, in pounds.

D. From February 1 through ~~April 30~~ May 31 it shall be lawful for any person to place, set and fish any *drift* gill net with a stretched mesh size not less than two inches, only for the harvest of river herring in the areas described in 4 VAC 20-430-50.

VA.R. Doc. No. R02-175; Filed May 1, 2002, 9:56 a.m.

TITLE 9. ENVIRONMENT

VIRGINIA WASTE MANAGEMENT BOARD

REGISTRAR'S NOTICE: Due to its length, the final regulation filed by the Virginia Waste Management Board is not being published. However, in accordance with § 2.2-4031 of the Code of Virginia, the summary is being published in lieu of the full text. The full text of the regulation is available for public inspection at the office of the Registrar of Regulations and at the Virginia Waste Management Board, 629 E. Main Street, Richmond, VA 23219, and is accessible at <http://legis.state.va.us/codecomm/register/vol18/iss18/welcome.htm>.

Title of Regulation: **9 VAC 20-120. Regulated Medical Waste Management Regulations (amending 9 VAC 20-120-10, 9 VAC 20-120-40 through 9 VAC 20-120-100, 9 VAC 20-120-120, 9 VAC 20-120-130, 9 VAC 20-120-150 through 9 VAC 20-120-180, 9 VAC 20-120-200 through 9 VAC 20-120-310, 9 VAC 20-120-330, 9 VAC 20-120-340, 9 VAC 20-120-360, 9 VAC 20-120-370, 9 VAC 20-120-380, 9 VAC 20-120-390, 9 VAC 20-120-410 through 9 VAC 20-120-480, 9 VAC 20-120-500, 9 VAC 20-120-530, 9 VAC 20-120-540, 9 VAC 20-120-560, 9 VAC 20-120-590, 9 VAC 20-120-640, 9 VAC 20-120-680 through 9 VAC 20-120-760, 9 VAC 20-120-810, 9 VAC 20-120-840, and 9 VAC 20-120-880; adding 9 VAC 20-120-835; repealing 9 VAC 20-120-20, 9 VAC 20-120-770 through 9 VAC 20-120-800, Appendix 10.1, and Appendix 10.4).**

Statutory Authority: § 10.1-1402 of the Code of Virginia.

Effective Date: June 19, 2002.

Summary:

The Regulated Medical Waste Management Regulations establish permit requirements for the storage, treatment and disposal of regulated medical wastes (RMW). Rules for packaging, labeling and transporting RMW, as well as exemptions from regulation, are also included. Five approved treatment processes are provided for as well as provisions for establishing alternate treatment technologies.

Final Regulations

The amendments (i) exempt certain medical waste from regulations, (ii) change the on-site storage permit requirements for small facilities, (iii) eliminate full permits for off-site medical waste storage, and (iv) replace medical waste packaging and transportation standards with those of other regulatory agencies.

The proposed regulation is changed as follows:

1. Definitions are modified for clarity.
2. The definition of "empty" is amended to reflect that materials are still regulated as regulated medical waste if they are subject to regulation under the OSHA bloodborne pathogen standard.
3. Clarification is provided indicating that all sharps are regulated medical waste including those used in veterinary practice.
4. Amendments are made to indicate that if wastes are managed in a container that is resistant to the elements, a covered loading area is not required.
5. The requirement for signage on the doors of RMW transporters is removed.
6. Amendments are made to allow shredding of RMW within 24 hours following treatment rather than immediately after treatment.

Summary of Public Comments and Agency Response: A summary of comments made by the public and the agency's response may be obtained from the promulgating agency or viewed at the office of the Registrar of Regulations.

Agency Contact: John E. Ely, Department of Environmental Quality, P.O. Box 10009, Richmond, VA 23240, telephone (804) 698-4249, FAX (804) 698-4327 or e-mail jeely@deq.state.va.us.

VA.R. Doc. No. R00-174; Filed May 1, 2002, 11:09 a.m.

Title of Regulations: **9 VAC 20-160. Voluntary Remediation Regulations (amending 9 VAC 20-160-10 through 9 VAC 20-160-40 and 9 VAC 20-160-60 through 9 VAC 20-160-120; repealing 9 VAC 20-160-50 and 9 VAC 20-160-130).**

Statutory Authority: § 10.1-1429.1 of the Code of Virginia.

Effective Date: July 1, 2002.

Summary:

The Voluntary Remediation Regulations encourage the remediation of properties not mandated by the Comprehensive Environmental Response, Compensation and Liability Act, 42 USC § 9601 et seq. (CERCLA); the Resource Conservation and Recovery Act, 42 USC § 6901 et seq. (RCRA); the Virginia Waste Management Act (§ 10.1-1400 et seq. of the Code of Virginia); State Water Control Law (§ 62.1-44.2 et seq. of the Code of Virginia); or other applicable authority. The regulations are amended to update documents incorporated by reference, and to clarify the regulations.

The following changes are made to the text of the proposed regulation:

1. Language is added to clarify that the risk assessment in a Voluntary Remediation Report will include an assessment of risk to surrounding properties.
2. Language is added that allows the department, when reviewing submittals, to request sampling data from sites or surrounding areas to verify the extent of contamination.
3. Changes are made to emphasize that for the participant to receive a certification of satisfactory completion of remediation, the participant must demonstrate that the site meets remediation levels and that the site will continue to meet remediation levels in the future for both on-site and off-site receptors.
4. The Risk-Based Concentration Table incorporated into the regulations is the US EPA Region III Risk-Based Concentration Table, revised April 2, 2002.

Summary of Public Comments and Agency's Response: A summary of comments made by the public and the agency's response may be obtained from the promulgating agency or viewed at the office of the Registrar of Regulations.

Agency Contact: Melissa Porterfield, Department of Environmental Quality, P.O. Box 10009, Richmond, VA 23240, telephone (804) 698-4238 or e-mail: msporterfi@deq.state.va.us.

REGISTRAR'S NOTICE: The proposed regulation was adopted as published in 18:3 VA.R. 300-311 October 22, 2001, with the additional changes shown below. Therefore, pursuant to § 2.2-4031 A of the Code of Virginia, the text of the final regulation is not set out at length; however, the changes from the proposed regulation are printed below.

9 VAC 20-160-10. Definitions.

The following words and terms, when used in this chapter, shall have the following meanings unless the context clearly indicates otherwise.

["~~Act~~" means the Voluntary Remediation Act (§ 10.1-1429.1 et seq. of the Code of Virginia).]

~~"Agreement" means the Voluntary Remediation Agreement entered into between the department and a Voluntary Remediation Program participant.~~

"*Authorized agent*" means any person who is authorized in writing to fulfill the requirements of this program.

~~"Baseline risk assessment" means the portion of a risk assessment which addresses the potential adverse human health and environmental effects under both current and planned future conditions caused by the presence of a contaminant in the absence of any control, remediation, or mitigation measures.~~

"*Carcinogen*" means a chemical classification for the purpose of risk assessment as an agent that is known or suspected to cause cancer in humans, including but not limited to a known or likely human carcinogen or a probable or possible human

carcinogen under an EPA weight-of-evidence classification system.

"Certificate" means a written certification of satisfactory completion of remediation issued by the director pursuant to § [~~40.1-1429.1~~ 10.1-1232] of the Code of Virginia.

"Completion" means fulfillment of the commitment agreed to by the participant as part of this program.

"Contaminant" means any man-made or man-induced alteration of the chemical, physical or biological integrity of soils, sediments, air and surface water or groundwater including, but not limited to, such alterations caused by any hazardous substance (as defined in the Comprehensive Environmental Response, Compensation and Liability Act, 42 USC § 9601(14)), hazardous waste (as defined in 9 VAC 20-60-40), solid waste (as defined in 9 VAC 20-80-10), petroleum (as defined in Articles 9 (§ 62.1-44.34:8 et seq.) and 11 (§ 62.1-44.34:14 et seq.)) of the Virginia State Water Control Law, or natural gas.

"Cost of remediation" means all costs incurred by the participant pursuant to activities necessary for completion of voluntary remediation at the site, based on an estimate of the net present value (NPV) of the combined costs of the site investigation, report development, remedial system installation, operation and maintenance, and all other costs associated with ~~the remedial action~~ *participating in the program and addressing the contaminants of concern at the site.*

"Department" means the Department of Environmental Quality of the Commonwealth of Virginia or its successor agency.

"Director" means the Director of the Department of Environmental Quality ~~or such other person to whom the director has delegated authority.~~

"Engineering controls" means ~~remedial actions directed toward containing or controlling the migration of contaminants through the environment~~ *physical modification to a site or facility to reduce or eliminate potential for exposure to contaminants.* These include, but are not limited to, stormwater conveyance systems, pump and treat systems, slurry walls, liner systems, caps, *monitoring systems, and leachate collection systems and groundwater recovery systems.*

"Hazard index (HI)" means the sum of more than one hazard quotient for multiple contaminants or multiple exposure pathways or both. The HI is calculated separately for chronic, subchronic, and shorter duration exposures.

"Hazard quotient" means the ratio of a single contaminant exposure level over a specified time period to a reference dose for that contaminant derived from a similar period.

"Incremental upper-bound lifetime cancer risk level" means a conservative estimate of the incremental probability of an individual developing cancer over a lifetime. Upper-bound lifetime cancer risk level is likely to overestimate "true risk."

"Institutional controls" means legal or contractual restrictions on property use that remain effective after remediation is completed, and are used to ~~meet remediation levels~~ *reduce or*

eliminate the potential for exposure to contaminants. The term may include, but is not limited to, deed and water use restrictions.

"Land use controls" means legal or physical restrictions on the use of, or access to, a site to reduce or eliminate potential for exposure to contaminants, or prevent activities that could interfere with the effectiveness of remediation. Land use controls include but are not limited to engineering and institutional controls.

"Noncarcinogen" means a chemical classification for the purposes of risk assessment as an agent for which there is either inadequate ~~toxicologic~~ *toxicological* data or is not likely to be a carcinogen based on an EPA weight-of-evidence classification system.

"Operator" means the person currently responsible for the overall operations at a site, or any person responsible for operations at a site at the time of, or following, the release.

"Owner" means any person currently owning or holding legal or equitable title or possessory interest in a property, including the Commonwealth of Virginia, or a political subdivision thereof, including title or control of a property conveyed due to bankruptcy, foreclosure, tax delinquency, abandonment, or similar means, ~~or any person who previously owned the property.~~

"Participant" means a person who has received confirmation of eligibility and has remitted payment of *the* registration fee.

"Person" means an individual, corporation, partnership, association, a governmental body, a municipal corporation or any other legal entity.

"Program" means the Virginia Voluntary Remediation Program.

"Property" means a parcel of land defined by the boundaries in the deed.

"Reference dose" means an estimate of a daily exposure level for the human population, including sensitive subpopulations, that is likely to be without an appreciable risk of deleterious effects during a lifetime.

"Registration fee" means the fee paid to enroll in the Voluntary Remediation Program, based on 1.0% of the total cost of remediation at a site, not to exceed the statutory maximum.

"Release" means any spilling, leaking, pumping, pouring, emitting, emptying, discharging, injecting, escaping, leaching, dumping or disposing of any contaminant into the environment.

"Remediation" means actions taken to cleanup, mitigate, correct, abate, minimize, eliminate, control and contain or prevent a release of a contaminant into the environment in order to protect human health and the environment, including actions to investigate, study or assess any actual or suspected release. *Remediation may include, when appropriate and approved by the department, land use controls.*

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"Remediation level" means the concentration of a contaminant ~~and with applicable land use controls, that are~~ is protective of human health and the environment.

"Report" means the Voluntary Remediation Report required by 9 VAC 20-160-70.

"Restricted use" means any use other than residential.

"Risk" means the probability that a contaminant will cause an adverse effect in exposed humans or to the environment.

"Risk assessment" means the process used to determine the risk posed by contaminants released into the environment. Elements include identification of the contaminants present in the environmental media, assessment of exposure and exposure pathways, assessment of the toxicity of the contaminants present at the site, characterization of human health risks, and characterization of the impacts or risks to the environment.

"Site" means any property or portion thereof, as agreed to and defined by the participant and the department, which contains or may contain contaminants being addressed under this program.

"Termination" means the formal discontinuation of participation in the Voluntary Remediation Program *without obtaining a certification of satisfactory completion.*

"Unrestricted use" means the designation of acceptable future use for a site at which the remediation levels, based on either background or standard residential exposure factors, have been attained throughout the site in all media.

~~*"Upper bound lifetime cancer risk level"* means a conservative estimate of the probability of one excess cancer occurrence in a given number of exposed individuals. For example, a risk level of 1×10^{-6} equates to one additional cancer occurrence in one million exposed individuals, beyond the number of occurrences that would otherwise occur. Similarly, a risk level of 1×10^{-4} equates to one additional cancer occurrence in 10,000 exposed individuals. Upper bound lifetime cancer risk level is based on an assumption of continuous, lifetime exposure and is likely to overestimate "true risk."~~

9 VAC 20-160-20 through 9 VAC 20-160-50. [No change from proposed.]

9 VAC 20-160-60. Registration fee.

A. In accordance with § [~~10.1-1429.1 A-5~~ 10.1-1232 A 5] of the Code of Virginia, the applicant shall submit a registration fee to defray the cost of the ~~voluntary remediation~~ program.

B. The registration fee ~~will~~ *shall* be at least 1.0% of the estimated cost of the remediation at the site, not to exceed the statutory maximum. Payment ~~will~~ *shall* be required after eligibility has been verified by the department and prior to technical review of submittals pursuant to 9 VAC 20-160-80. Payment shall be made payable to the Commonwealth of Virginia and remitted to Virginia Department of Environmental Quality, P.O. Box 10150, Richmond, VA 23240.

C. To determine the appropriate registration fee, the applicant may provide ~~a remediation cost~~ *an estimate of the total*

~~anticipated total cost based upon net present value of remediation at the site.~~

~~Remediation costs shall be based on site investigation activities; report development; remedial system installation, operation and maintenance; and all other costs associated with participating in the program and addressing the contaminants of concern at the subject site.~~

Departmental concurrence with ~~a~~ *an estimate of the cost of remediation cost estimate* does not constitute approval of the remedial approach assumed in the cost estimate.

The participant may elect to remit the statutory maximum registration fee to the department as an alternative to providing an estimate of the total cost of remediation at the time of eligibility verification.

~~D. Upon submittal of the demonstration of completion (see 9 VAC 20-160-70 A-2) If the participant does not elect to submit the statutory maximum registration fee, the participant will shall provide the department with the actual total cost of the remediation, and prior to issuance of a certificate. The director will department shall calculate any balance adjustments to be made to the initial registration fee. Any negative balance owed to the department shall be paid by the participant prior to the issuance of a certification of satisfactory completion of remediation certificate. Any costs to be refunded shall be remitted by the agency department with issuance of the certificate of satisfactory completion of remediation.~~

~~E. As an alternative to providing a remedial cost estimate at the time of eligibility verification, If the participant may elect elected to remit the statutory maximum registration fee-, the department will shall refund any balance owed to the participant after receiving the actual total cost of remediation submitted with the demonstration of completion and issuance of the certification of satisfactory completion of remediation. If no remedial cost summary is provided to the department within 60 working days of the participant's receipt of the department's concurrence with the demonstration of completion certificate, the participant will have waived the right to a refund.~~

9 VAC 20-160-70. Work to be performed.

A. The Voluntary Remediation Report serves as the ~~master document archive~~ for all documentation pertaining to remedial activities at the site. Each component of the report shall be submitted by the participant to the department. As various components are received, they shall be inserted into ~~this the report by the participant, and the report will serve as the documentation archive for the site. It~~ *The report shall consist of a site characterization, [a] risk assessment [including an assessment of risk to surrounding properties] (as appropriate), [a] remedial action work plan and, when applicable, a demonstration of completion, and documentation of public notice.*

~~1. Site characterization/remedial action plan. This component of the report shall consist of the following:~~

~~a. 1. The site characterization component of the submittal should shall contain a delineation of the nature and extent of releases to all media, including the vertical and horizontal extent of the contaminants.~~

2. The risk assessment shall contain an evaluation of the risks to human health and the environment posed by the release, a proposed set of remediation levels consistent with 9 VAC 20-160-90 that are protective of human health and the environment, and a recommended remedial action remediation to achieve the proposed objectives; or a justification demonstration that no action is necessary.

b. 3. The remedial action work plan component of the submittal shall propose the activities, schedule, any permits required to initiate and complete the remedial action remediation and specific design plans for implementing a remedial action remediation that will achieve the remediation levels specified in the site characterization risk assessment. Control or elimination of continuing onsite source or sources of releases to the environment shall be discussed. Land use controls should be discussed as appropriate.

c. Documentation of the public notice in accordance with 9 VAC 20-160-120. Such documentation shall include a written summary of comments received as well as the applicant's responses to the comments that were received during the public comment period.

2. 4. Demonstration of completion.

a. This closure component of The report demonstration of completion should, when applicable, include a detailed summary of the performance of the remedial action remediation implemented at the site, the total cost of the remediation, and, as necessary, confirmational sampling results demonstrating that the established site-specific remedial objectives have been achieved, or that other criteria for completion of remediation have been satisfied. If the participant elected to remit the statutory maximum registration fee and is not seeking a refund of any portion of the registration fee, the total cost of remediation need not be provided.

b. As part of the demonstration of completion, the participant shall certify compliance with applicable regulations pertaining to activities performed at the site pursuant to this chapter.

5. The participant shall provide documentation that public notice has been provided in accordance with 9 VAC 20-160-120. Such documentation shall include copies of comments received during the public comment period, all acknowledgements of receipt of comments, as well as the participant's responses to comments, if any are made.

B. It is the participant's responsibility to ensure that the conduct of investigation and remediation activities (e.g., waste management and disposal, erosion and sedimentation controls, air emission controls, and activities that impact wetlands and other sensitive ecological habitats) comply with all applicable regulations and any appropriate regulations that are not required by state or federal law but are necessary to ensure that the activities do not result in a further release of contaminants to the environment and are protective of human health and the environment.

C. All work shall be performed in accordance with Test Methods for Evaluating Solid Waste, USEPA SW-846, revised

December 1987 April 1998, or other methods approved by the department.

9 VAC 20-160-80. Review of submittals.

A. Upon receipt of submittals, the director will department shall review and evaluate the submittals. The director department may request additional information [, including sampling data of the site or areas adjacent to the site to verify the extent of the release,] in order to render a decision and move the participant towards expeditious issuance of the certification of satisfactory completion of remediation certificate.

B. The director may expedite, as appropriate, issuance of any permits required to initiate and complete a voluntary remediation. The director shall, within 120 working days of a complete submittal, expedite issuance of such permit in accordance with applicable regulations.

C. The participant shall submit a final voluntary remediation report (consisting of the site characterization, the remedial action work plan, and the demonstration of completion). Upon receipt of After receiving a complete Voluntary Remediation report, the director will shall make a determination regarding the issuance of the certification of satisfactory completion of remediation certificate to the participant. The determination shall be a final agency action pursuant to the Administrative Process Act (§ 9-6.14:1 2.2-4000 et seq. of the Code of Virginia).

9 VAC 20-160-90. [No change from proposed.]

9 VAC 20-160-100. [No change from proposed.]

9 VAC 20-160-110. Certification of satisfactory completion of remediation.

A. Upon termination of program participation according to 9 VAC 20-160-100 A 1, The director shall issue a certification of satisfactory completion of remediation (certificate) when:

1. The participant has demonstrated that migration of contamination has been stabilized;
2. The participant has demonstrated that the site has met remediation levels and will continue to meet remediation levels in the future [for both on site and off site receptors]; and
3. The department concurs with all work submitted, as set forth in 9 VAC 20-160-80.

B. The issuance of the certificate shall constitute immunity to an enforcement action under the Virginia Waste Management Act (§ 10.1-1400 et seq. of the Code of Virginia), the Virginia State Water Control Law (§ 62.1-44.2 et seq. of the Code of Virginia), the Virginia Air Pollution Control Law (§ 10.1-1300 et seq. of the Code of Virginia), or other applicable Virginia law.

C. The certificate shall be issued by the director and, If a use restriction is specified in the certificate, such restriction must be attached to the deed and include to the property with an explanation for such the restriction, subject to concurrence by the director, and shall be recorded by the participant with the land records for the site in the office of the clerk of the circuit court for the jurisdiction in which the site is located. The

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participant may also record the certificate itself. If the certificate does not include any use restriction, recordation of the certificate is at the option of the participant. The immunity accorded by the certification shall apply to the participant and shall run with the land identified as the site.

D. The immunity granted by issuance of the certificate shall be limited to site conditions at the time of issuance as those conditions are described in the Voluntary Remediation Report ~~and is conditioned upon completeness and accuracy of that information. The immunity is further conditioned upon satisfactory performance by the participant of all obligations required by the director under the program and upon the veracity, accuracy, and completeness of the information submitted to the director by the participant relating to the site.~~ Specific limitations of the certificate shall be enumerated in the certificate. The immunity granted by the certificate ~~will~~ shall be dependent upon the identification of the nature and extent of contamination as presented in the Voluntary Remediation report.

E. The certificate shall specify the site conditions for which immunity is being accorded, including, but not limited to:

1. A summary of the information that was considered;
2. Any restrictions on future use;
3. *Any local land use controls on surrounding properties that were taken into account; and*
- ~~3- 4. Any required institutional land use controls; and including:~~
 - ~~4. Any required~~ a. Engineering controls and their maintenance; and
 - b. Institutional controls.

F. The certificate may be revoked by the director at any time in the event that ~~contamination posing an unacceptable conditions at the site, unknown at the time of issuance of the certificate, pose a risk to human health or the environment is rediscovered on-site~~ or in the event that it is discovered that the certificate was based on information ~~provided by the participant~~ that was materially false, inaccurate, or misleading. *Any and all claims may be pursued by the Commonwealth for liability for failure to meet a requirement of the program, criminal liability, or liability arising from future activities at the site that may cause contamination by pollutants.* By issuance of the certificate the ~~department~~ director does not waive sovereign immunity.

G. *The certificate is not and shall not be interpreted to be a permit or a modification of an existing permit or administrative order issued pursuant to state law, nor shall it in any way relieve the participant of its obligation to comply with any other federal or state law, regulation or administrative order. Any new permit or administrative order, or modification of an existing permit or administrative order, must be accomplished in accordance with applicable federal and state laws and regulations.*

9 VAC 20-160-120. [No change from proposed.]

9 VAC 20-160-130. [No change from proposed.]

DOCUMENTS INCORPORATED BY REFERENCE

Test Methods for Evaluating Solid Waste: *Physical/ Chemical Methods*; EPA Publication SW-846, Third Edition (1986) ~~with Revision 1~~ as amended by *Final Update I, Final Update II, Final Update IIA, Final Update IIB, Final Update III, and Final Update IIIA*, PB 88-239223 99-115 891, revised ~~December 1987~~ April 1998.

U.S. EPA Soil Screening Guidance, ~~EPA/540/F-95/044 EPA/540/R-96/018~~, Publication 93554-14FSA, PB96-963504 9355.4-23, July 1996.

Risk Assessment Guidance for Superfund, Volume I, Human Health Evaluation Manual (Part A) Interim Final, EPA/540/1-89/002, Office of Emergency and Remedial Response, U.S. Environmental Protection Agency, December 1989.

Risk Assessment Guidance for Superfund: Volume I - Human Health Evaluation Manual (Part B, Development of Risk-based Preliminary Remediation Goals) Interim, Publication 9285.7-01B, Office of Emergency and Remedial Response, U.S. Environmental Protection Agency, December 1991.

Risk-Based Concentration Table, Region III, United States Environmental Protection Agency, ~~January-June 1996 [October 5, 2000 April 2, 2002]~~.

VA.R. Doc. No. R01-9; Filed May 1, 2002, 11:07 a.m.



TITLE 12. HEALTH

STATE BOARD OF HEALTH

Title of Regulation: **12 VAC 5-615. Authorized Onsite Soil Evaluator Regulations.**

Statutory Authority: §§ 32.1-163.5 and 32.1-164 of the Code of Virginia.

Effective Date: July 1, 2002.

Summary:

These regulations allow the agency to accept private site evaluations and designs, in compliance with the Board of Health's regulations for onsite sewage systems, designed and certified by an authorized onsite soil evaluator (AOSE) or a licensed professional engineer (PE) in consultation with an AOSE.

Amendments made to the proposed regulations are as follows:

- 1. Language was added to provide that the Virginia Department of Health (VDH) may accept evaluations and designs for proprietary pre-engineered systems that have been deemed by VDH to comply with the board's regulations; however, these are not subject to time limits or deemed approval.*

2. The "sunset date" was changed from December 31, 2002, to December 31, 2005.

3. Language has been added to emphasize that VDH has discretion in choosing whether to initiate permit revocation proceedings and to encourage VDH to modify approvals, with the owner's consent, rather than revoke them.

4. Amendments provide that the AOSE is not required to modify a permit if the owner damages the approved site.

5. The requirements for inspecting sewage systems at the time of installation are changed. VDH may, but is not required to, perform such final inspections of AOSE/PE designed systems.

6. Traditional systems have been defined to include provisional, general, proprietary pre-engineered and other systems contained in 12 VAC 5-610 (the Sewage Handling and Disposal Regulations).

7. Amendments eliminate the requirement that all currently certified AOSEs pass written and field tests by the "sunset date."

8. VDH employees are required to pay the AOSE application fee.

9. Requests for professional courtesy reviews must include a statement from the owner giving VDH permission to enter the property.

Summary of Public Comments and Agency's Response: A summary of comments made by the public and the agency's response may be obtained from the promulgating agency or viewed at the office of the Registrar of Regulations.

Agency Contact: Donald J. Alexander, Director, Division Onsite Sewage Water Services, Department of Health, Office of Environmental Health Services, Room 115, P.O. Box 2448, Richmond, VA 23218, telephone (804) 786-1620 or FAX (804) 225-4003.

REGISTRAR'S NOTICE: The proposed regulation was adopted as published in 18:2 VA.R. 140-159 October 8, 2001, with the additional changes shown below. Therefore, pursuant to § 2.2-4031 A of the Code of Virginia, the text of the final regulation is not set out at length; however, the changes from the proposed regulation are printed below.

CHAPTER 615.

AUTHORIZED ONSITE SOIL EVALUATOR REGULATIONS.

PART I.

GENERAL PROVISIONS.

12 VAC 5-615-10. Authority for regulations.

Section 32.1-164 of the Code of Virginia provides that the State Board of Health has the duty to qualify individuals as authorized onsite soil evaluators (AOSEs) and establish procedures for utilizing the work of AOSEs and professional engineers (PEs) in consultation with AOSEs when issuing construction permits, certification letters, and subdivision approvals. Section 32.1-163.4 of the Code of Virginia provides that the department shall contract with an AOSE for the field evaluation of backlogged application sites and that the

department shall only accept private evaluations from AOSEs. Section 32.1-163.5 of the Code of Virginia provides that the department shall accept private evaluations and designs for residential development from an AOSE or a PE in consultation with an AOSE and that the department is not required to perform a field check of such evaluations and designs prior to issuing an approval [: ; the department may, although it is not required to, accept evaluations and designs from an AOSE or a PE in consultation with an AOSE for a proprietary, pre-engineered system that has been deemed by the department to comply with the board's regulations.]

12 VAC 5-615-20, 12 VAC 5-615-30, and 12 VAC 5-615-40. [No change from proposed.]

12 VAC 5-615-50. Authorized Onsite Soil Evaluator Advisory Committee.

The commissioner shall appoint an Authorized Onsite Soil Evaluator Advisory Committee consisting of up to [44 15] appointed members and one ex officio member. The commissioner shall appoint members to the Authorized Onsite Soil Evaluator Advisory Committee as follows: four AOSEs from four different regions of the Commonwealth, one or more of whom must be a member of the Virginia Association of Professional Soil Scientists; four individuals currently employed by the department as Environmental Health Specialist Senior (these may or may not also be AOSEs); two persons actively engaged in the installation of onsite sewage systems; one professional engineer; [one person who is a realtor licensed in Virginia;] and three discretionary voting positions intended to provide substantive expertise, when needed, from the following categories (but not limited to these categories): Homebuilder/Developer, Well Driller, Local Government, Lending Institution, Surveyor. Each member of the advisory committee may be appointed to serve a term of two years; however, the commissioner, when making initial appointments, shall designate seven of the members to serve terms of three years. The appointment, renewal and removal of each advisory committee member lies in the sole discretion of the commissioner. The commissioner should seek to ensure that one or more members of the advisory committee is a homeowner with experience with onsite sewage systems so that homeowner's interests may be represented on the committee. The director of the division, or a designee, shall serve as an ex officio member of the advisory committee. The commissioner shall designate [that] the chairman of the committee and members shall serve at the discretion of the commissioner. The committee shall make recommendations to the commissioner regarding AOSE/PE policies, procedures, and programs. The committee shall meet at least annually. The committee shall establish its rules of order.

12 VAC 5-615-60. Scope of regulations.

A. This chapter describes the content and form of site and soil evaluation reports submitted to the department by an AOSE/PE pursuant to an application filed for an approval under the Sewage Handling and Disposal Regulations (12 VAC 5-610-20 et seq.). The department will accept applications from owners (or their agents) without any site evaluation work (bare applications), with complete supporting documentation from an AOSE/PE, and until December 31, [2002 2005], with complete supporting documentation from

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non-AOSE/PE consultants. After December 31, [~~2002~~ 2005], the department will [continue to accept bare applications from owners (or their agents) and will] only accept site evaluation reports and designs from AOSE/PEs.

B. The provisions of local ordinances regarding onsite wastewater systems that are more restrictive than, and not inconsistent with, the Sewage Handling and Disposal Regulations are not affected by this regulation unless a locality indicates in writing to the commissioner that it wants the department to apply its more restrictive ordinances in concert with the provisions of this chapter. When such a request is made, the department will require all AOSE/PE reports submitted in the locality to be certified as complying with both the Sewage Handling and Disposal Regulations and the more restrictive local requirements and implement the provisions of the more restrictive ordinances pursuant to this chapter. In those localities with more restrictive ordinances where the local government has not indicated to the commissioner in writing that it desires that the provisions of this chapter be applied to the more restrictive ordinances, the department will review all applications for compliance with state law and regulations only. Such applicants then must obtain a certification of compliance with local ordinances from a local official. The department shall maintain a list of all localities that have notified the commissioner in writing pursuant to this section.

C. The department may accept evaluations and designs from AOSE/PEs in accordance with this chapter that include a certification as to the suitability of sites for the construction of private wells in accordance with the Private Well Regulations (12 VAC 5-630 [~~-40 et seq.~~]).

12 VAC 5-615-70. Roles and responsibilities.

A. An AOSE/PE must certify that a site meets or does not meet the requirements of either the Sewage Handling and Disposal Regulations (12 VAC 5-610 [~~-20 et seq.~~]), the Private Well Regulations (12 VAC 5-630 [~~-20 et seq.~~]), or both, and may design [certain] traditional systems in accordance with the same regulations. Responsibility for assuring that site evaluations and designs comply with the Sewage Handling and Disposal Regulations or the Private Well Regulations rests with the AOSE/PE submitting the work.

B. The Department of Health shall have the following responsibilities:

1. The department's role in evaluating an AOSE/PE submission will be to review the materials submitted with an application [~~for~~ as it deems necessary to assure] compliance with this chapter, the Sewage Handling and Disposal Regulations, the Private Well Regulations and the department's policies prior to approval or disapproval of an application.

2. The department is not required to conduct a field check of any evaluation and/or design submitted pursuant to this chapter prior to issuing the appropriate approval; however, it will conduct such field reviews as it deems necessary to protect public health and the environment and to assess the performance of AOSE/PEs.

3. When requested by an AOSE/PE prior to the filing of an application for a construction permit or certification letter, the department may provide a site-specific field review consultation. Such requests shall not be included in any calculation of backlogs nor shall they be subject to the time limits contained in 12 VAC 5-615-80 or to deemed approval. The department may limit the number of such professional courtesy reviews provided to any individual AOSE/PE as it deems reasonable and as its resources allow. The professional courtesy review shall not be considered to be a case decision.

4. The department may provide professional courtesy reviews as it deems reasonable and as its resources allow when requested by an AOSE/PE in conjunction with a proposed subdivision, provided such field reviews are general in nature (not site-specific) and provided the developer or owner has generated a base map or preliminary plat of the proposed subdivision and provided that the request for review is made prior to any submission of a subdivision package to the local government for consideration under local subdivision ordinances. Such professional courtesy reviews shall be voluntary and within the sole discretion of the department and shall not be subject to any time limits. Professional courtesy reviews shall not be considered to be case decisions.

5. Whenever the department has approved a permit, certification letter, or subdivision approval in reliance upon an AOSE/PE certification and later has reason to believe that the site or sites or system design submitted by the AOSE/PE does not substantially comply with the minimum requirements of the Sewage Handling and Disposal Regulations, the department [~~shall~~ may] initiate proceedings, in accordance with the Sewage Handling and Disposal Regulations, to revoke [or modify] its approval. Such approvals, when revoked, shall be deemed to be permit denials and may be appealed by the aggrieved named party to the Sewage Handling and Disposal Appeal Review Board in accordance with § 32.1-166.6 of the Code of Virginia. All requests for appeals to the Appeal Review Board must be in writing and received by the commissioner within 30 days of receipt of notice of the revocation. [With the written consent of the owner, the department may revise a permit, certification letter, or subdivision approval to substantially comply with the Sewage Handling and Disposal Regulations. The owner may be required to file a new application and to provide formal or informal plans if such plans are required under the Sewage Handling and Disposal Regulations.]

C. An AOSE/PE must make minor revisions that are discovered to be necessary at any time, including, but not limited to, during the installation of the system, to a permit, certification letter or subdivision approval issued in reliance on the evaluations and/or designs of an AOSE/PE. [This subsection shall not be construed to require an AOSE to make revisions, minor or major, that result from actions taken by the owner including, but not limited to, improper site grading, improper location of structures, removal, compaction or other damages to soils.]

1. Minor revisions do not include changes in design flow or substantive changes in square footage of absorption area.
2. All revisions must fully comply with the Sewage Handling and Disposal Regulations and must be approved by the department before the issuance of the operation permit.
3. Whenever major revisions, such as changes in system design or location, are required, a new application in accordance with Part [~~III~~ IV] (12 VAC 5-615- [~~249~~ 340] et seq.) of this chapter shall be required.

D. Whenever a construction permit has been issued pursuant to a design certified by an AOSE/PE, the certifying AOSE/PE shall inspect that system at the time of installation and provide an inspection report [, including an "as-built" drawing,] and completion statement to the [owner and the] local health department. The inspection report and completion statement shall be in a form approved by the division and shall state that the AOSE/PE has inspected the installation. It shall state any deficiencies discovered and identify the methods of correction, and it shall state that the system was installed in accordance with the construction permit, approved plans where appropriate, and the requirements of 12 VAC 5-610 [~~20 et seq~~] . The local or district health department [~~shall also may,~~ but is not required to,] perform an inspection of such systems as required under 12 VAC 5-610-320. Whenever an AOSE/PE is unable to conduct an inspection under this section, the owner may provide an inspection report and completion statement executed by another AOSE or PE. An Operation Permit (12 VAC 5-610-340) shall not be issued for any system until the appropriate report and completion statement have been received by the local or district health department.

E. When the department has issued a construction permit for a private well only (no onsite sewage system), in reliance on a certification by an AOSE/PE, the construction inspection required by 12 VAC 5-630-320 will be performed by the local or district health department. In such cases, the owner shall provide to the local or district health department a written inspection statement signed by the AOSE/PE stating that the private well was installed in accordance with the permit and the Private Well Regulations. Whenever an AOSE/PE is unable to conduct an inspection under this section, the owner may provide an inspection report and completion statement executed by another AOSE or PE.

12 VAC 5-615-80. Processing time limits and deemed approval.

A. The provisions of this section apply only to applications for residential development [and do not apply to any application for a proprietary, pre-engineered system that has been deemed by the department to comply with the board's regulations. The department may accept evaluations and designs for proprietary, pre-engineered systems in accordance with this chapter; however, the processing time limits and deemed approval shall not apply to any such application].

B. The department shall review applications submitted with AOSE/PE documentation in the form specified in this chapter and shall issue a written approval or denial within the time frames specified in Table 1 of this subsection. In the event the

application is denied, the department shall set forth in writing the reasons for denial.

Table 1

| Type of Application | Time Limit |
|-----------------------------------|-----------------|
| Individual Permit Application | 15 working days |
| Individual Certification Letter | 20 working days |
| Multiple Lot Certification Letter | 60 days |
| Subdivision Review | 60 days |

C. If the department does not approve or disapprove an AOSE/PE application or a request for a subdivision review properly submitted in accordance with this chapter within the time limits specified in Table 1, the application [or request for subdivision review] shall be deemed approved and the appropriate letter, permit, or approval shall be issued.

12 VAC 5-615-90, 12 VAC 5-615-100, and 12 VAC 5-615-110. [No change from proposed.]

12 VAC 5-615-120. Definitions.

The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"AOSE/PE" means an authorized onsite soil evaluator or a professional engineer working in consultation with an authorized onsite soil evaluator.

"Authorized onsite soil evaluator (AOSE)" means a person currently listed by the board as possessing the qualifications to evaluate soils and soil properties in relationship to the effects of these properties on the use and management of these soils as the locations for traditional onsite sewage disposal systems.

"Backlog" is deemed to exist when the processing time for more than 10% of a local or district health department's complete bare applications for construction permits exceeds a predetermined number of working days (i.e., a 15-day backlog exists when the processing time for more than 10% of permit applications exceeds 15 working days). When calculating backlogs, only applications for construction permits shall be counted. [~~Working days characterized by severe weather conditions shall not be included in any backlog calculation.~~]

"Bare application" means an application for a construction permit or a certification letter submitted without supporting documentation from an AOSE/PE.

"Board" means the State Board of Health.

"Certification letter" means a letter issued by the department, in lieu of a construction permit, that identifies a specific site and recognizes the appropriateness of the site for an onsite wastewater disposal system.

"Complete application" means an application for a construction permit or certification letter that includes all necessary information needed to process the application as specified in 12 VAC 5-610-250 including a site plan as specified in 12 VAC 5-610-460.

"Deemed approved" or "deemed approval" means that the department has not taken action to approve or disapprove an

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application for a permit, an individual lot certification letter, multiple lot certification letters, or subdivision approval for residential development within the time limits prescribed in §§ 32.1-163.5 and 32.1-164 H of the Code of Virginia. In such cases, an application submitted in proper form pursuant to this chapter is deemed approved and the appropriate letter or letters, permit, or approval shall be immediately issued by the department. Deemed approval applies only to applications for single-lot construction permits, subdivision review, and single or multiple-lot certification letters submitted with evaluations and designs certified by an AOSE/PE in accordance with the provisions of the Code of Virginia, the Sewage Handling and Disposal Regulations, and this chapter. Sites that have been previously denied by the department [and proprietary, pre-engineered systems deemed by the department to comply with the board's regulations] are not subject to the provisions of deemed approval. An application "deemed approved" means that it is approved only with respect to the Board of Health's regulations. In accordance with 12 VAC 5-615-60 B a local government may authorize the department in writing to implement the provisions of any local ordinance that are more restrictive than the Sewage Handling and Disposal Regulations through the provisions of this chapter.

"Multiple lot certification letters" means two or more applications for certification letters filed by the same owner for existing or proposed lots to serve detached, individual dwellings.

"Professional courtesy review" means a site-specific field review requested by an AOSE/PE prior to the submission of an application for a construction permit or certification letter or a general field consultation (not site-specific) regarding a proposed subdivision.

"Professional engineer in consultation with an AOSE" means that a professional engineer has communicated with an AOSE regarding the site and soil conditions present where the system is proposed, in a manner sufficient to assure compliance with the Sewage Handling and Disposal Regulations and this chapter.

"Processing time" means the number of working days from the date a complete, bare application is received by a local or district health department to the date a permit or certification letter is issued. [Working days characterized by severe weather conditions shall not be included in any calculation of processing time.]

"Residential development" means development, including repair or replacement systems in accordance with 12 VAC 5-610-280 C 2, using single family homes, which utilize individual onsite sewage systems for each structure. Mass drainfields and other cluster systems that serve more than one dwelling are not considered residential development for the purposes of this chapter.

"Single lot construction permit/certification letter" means one application filed by an owner for a sewage disposal system construction permit or certification letter to serve an individual dwelling on one lot or parcel of land.

"Subdivision review" means the review of a proposed subdivision plat by a local health department for a local government pursuant to a local ordinance or ordinances and

pursuant to §§ 15.2-2242 and 15.2-2260 of the Code of Virginia and 12 VAC 5-610-360 of the Sewage Handling and Disposal Regulations for the purposes of determining and documenting whether an approved sewage disposal site is present on each proposed lot.

"Traditional systems" means onsite wastewater treatment and disposal systems [, including proprietary, pre-engineered systems deemed by the department to comply with the board's regulations, that have received provisional or general approval under, or] for which design criteria are contained in [,] the Sewage Handling and Disposal Regulations, except as noted below. [~~At present, traditional systems include gravity, pumped, and low pressure distribution (lpd) septic effluent drainfields, and Wisconsin-type mound systems.~~ For the purposes of this chapter,] traditional systems [~~as defined in this regulation~~] do not include experimental permits, conditional permits issued for temporary, intermittent or seasonal use, septage stabilization systems, or systems permitted under a soil drainage management plan. Conditional construction permits issued for limited occupancy or the use of permanent water saving fixtures are not excluded (see 12 VAC 5-610-250 J).

PART II.

COMPLIANCE WITH ADMINISTRATIVE PROCESS ACT.

12 VAC 5-615-130 through 12 VAC 5-615-200. [No change from proposed.]

PART III.

AOSE CERTIFICATION REQUIREMENTS.

12 VAC 5-615-210. Persons holding a valid certificate on [~~the effective date of these regulations~~ July 1, 2002].

Any person holding a valid certificate as an AOSE on [~~the effective date of these regulations who has not passed the AOSE written and field tests dated January 2000 or later must do so on or before December 31, 2002. Any such person whose AOSE certification expires prior to passing the AOSE written and field test~~ July 1, 2002,] may apply for renewal in accordance with 12 VAC 5-615-270 [; however, .] Such individuals [~~must~~ will not be required to] pass the written and field tests [~~on or before December 31, 2002~~].

12 VAC 5-615-220. [~~Construction permit in lieu of field test~~ (Reserved)].

[~~Any AOSE required to pass the field portion of the AOSE test pursuant to 12 VAC 5-615-210 may submit to the department a construction permit application package that he prepared that was approved for issuance of a permit and was satisfactorily reviewed in the field by a representative of the department in lieu of taking and passing the field test.~~]

12 VAC 5-615-230 and 12 VAC 5-615-240. [No change from proposed.]

12 VAC 5-615-250. Fees for applications, training, and testing.

A. The following fees will be assessed. All fees due the department shall be paid by check or money order.

B. Any person making application for certification as an AOSE or applying for renewal of an AOSE certification shall pay an

application fee of \$100. [~~Those persons currently employed by the department shall not be required to pay the application fee.~~]

C. Those persons taking a department-sponsored training course or courses as specified in 12 VAC 5-615-230 shall pay the fee for such course as determined by the department. Fees for such course or courses will be based on the department's actual expenses in preparing course materials and conducting the training. This section is not intended to prevent or discourage training courses recognized by the department and offered by entities other than the department. In the case of training that is not directly sponsored by the department, applicants will pay appropriate fees to the sponsoring entity.

D. Those persons taking written and field tests specified in 12 VAC 5-615-230 shall pay a fee for such testing as determined by the department based on the actual costs of preparing and administering the tests.

12 VAC 5-615-260 through 12 VAC 5-615-290. [No change from proposed.]

12 VAC 5-615-300. Application for reinstatement of AOSE certification.

Any person whose AOSE certification has been revoked pursuant to 12 VAC 5-615-290 may apply to the department for reinstatement as an AOSE no sooner than 12 months after the effective date of the revocation. Any person making application for [~~reimbursement~~ reinstatement] of an AOSE certification pursuant to this section shall:

1. File a complete application in a form approved by the division and pay the application fee in accordance with 12 VAC 5-615-250. The AOSE application for reinstatement must also include a certification that the AOSE has not engaged in AOSE activities after his certification was revoked [- ; and]

2. Provide documentation that the applicant has satisfactorily completed any remedial actions required as a result of the revocation. Remedial actions including, but not limited to, additional training courses, additional testing, and reevaluation of a site and/or redesign of an onsite sewage system may be specified as conditions for reinstatement.

12 VAC 5-615-310. Appeal of suspension or revocation.

In accordance with 12 VAC 5-615-180, any person whose AOSE certification has been suspended or revoked shall have the right to review by the appropriate circuit court.

12 VAC 5-615-320. AOSE/PE cannot certify a site that has been previously denied by the department.

No AOSE/PE shall certify a site as meeting the minimum requirements of the Sewage Handling and Disposal Regulations (12 VAC 5-610-20 et seq.) if the department has previously denied that site.

[~~Exception~~ Exceptions]:

- [1.] An AOSE/PE may certify a previously denied site as meeting the requirements of the Sewage Handling and Disposal Regulations if the board's regulations or policies

have changed in such a way that the site is suitable for a system that was not allowed by the board's prior regulations or policies at the time of the original denial [- ; and

2.] An AOSE/PE may certify as meeting the requirements of the Sewage Handling and Disposal Regulations a site located on the same property as a site previously denied by the department if the site being certified is not the same one that was denied by the department.

12 VAC 5-615-330. [No change from proposed.]

PART IV.
PROCEDURES AND REPORTS.

12 VAC 5-615-340. Application processing.

A. All applications that are submitted with evaluation and design documentation by an AOSE/PE shall contain the minimum required information necessary to complete the application and shall be accompanied by the required fees. Such applications when submitted for residential development will be processed within specified time limits in 12 VAC 5-615-80.

B. When such an application is found to be complete an approval may be issued without field review.

C. Applications that are found to be incomplete or defective in any manner shall be denied and the owner and AOSE/PE will be notified of deficiencies. If an application has been denied, the owner or [~~their~~ his] agent may submit a new application to correct the deficiency or deficiencies contained in [~~their~~ his] first application. If the application is received within 90 days, the department will waive all state fees associated with the new application. This waiver may be granted not more than once per site.

12 VAC 5-615-350. Documentation requirements for AOSE/PE reports.

A. Applications may be submitted for a single lot construction permit, a single lot certification letter, multiple lot certification letters, and subdivision reviews. The minimum requirements for each type of application are listed below. Additional information may be submitted when an AOSE/PE believes it may be in the [~~client's~~] interest [~~to provide additional information~~ of public health, the environment, or the client].

B. A complete application for a construction permit shall consist of the following:

1. A complete application for a Sewage Disposal System Construction Permit (CHS 200), signed, dated, and with all pertinent information supplied;

2. The appropriate fee for the application as per the Code of Virginia;

3. A site evaluation report in accordance with 12 VAC 5-615-360 and the department's policies;

4. A proposed well site (when a private water supply is proposed);

5. Construction drawings and specifications for the recommended system in accordance with 12 VAC 5-615-380 and the department's policies; and

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6. A statement in accordance with 12 VAC 5-615-70, 12 VAC 5-615-280, and 12 VAC 5-615-380 C certifying that the site and soil conditions and design conform with the Sewage Handling and Disposal Regulations (12 VAC 5-610)].

C. A complete application for certification letter differs from an equivalent application for a construction permit in that a complete design is not required. It is, however, necessary to assure a system meeting the requirements specified on the application can be supported by the proposed site. Therefore, the requirements for a single certification letter are:

1. A complete application for a Sewage Disposal System Construction Permit (CHS 200), signed, dated, and with all pertinent information supplied;
2. The appropriate fee for the application;
3. A site evaluation report in accordance with 12 VAC 5-615-360 and the department's policies;
4. A proposed well site (when a private water supply is proposed);
5. An abbreviated system design for the type of system proposed in a form approved by the division; and
6. A statement in accordance with 12 VAC 5-615-70, 12 VAC 5-615-280, and 12 VAC 5-615-380 C certifying that the site and soil conditions and design conform with the Sewage Handling and Disposal Regulations.

D. Applications for multiple certification letters may be used as the method for reviewing proposed subdivisions in localities that do not require the local health department to review proposed subdivisions. Each application submitted must contain the following:

1. Complete applications for Sewage Disposal System Construction Permits (CHS 200), signed, dated, and with all pertinent information supplied;
2. The appropriate fee for each site to be reviewed;
3. Site evaluation reports in accordance with 12 VAC 5-615-360 and the department's policies;
4. Proposed well sites (when a private water supply is proposed);
5. Abbreviated system designs for the type of system proposed in a form approved by the division;
6. A statement in accordance with 12 VAC 5-615-70, 12 VAC 5-615-280, and 12 VAC 5-615-380 C for each proposed site certifying that the site and soil conditions and design conform with the Sewage Handling and Disposal Regulations; and
7. If the multiple certification letters are intended to establish the suitability of soils for a proposed subdivision, the information specified in subdivision E 3 c of this section is to be submitted by the applicant.

E. Section 32.1-163.5 of the Code of Virginia provides that the department shall accept private site evaluations and designs, for subdivision review for residential development, designed

and certified by a licensed professional engineer in consultation with an AOSE or by an AOSE. The following shall apply to all requests for subdivision review and approval:

1. All requests for subdivision reviews must be submitted to the local health department with a request from the local government entity specifically asking for review of the proposed lots for onsite wastewater system approvals pursuant to the local ordinance governing such proposals (cite reference to local ordinance).

2. In localities where there is no subdivision ordinance, subdivisions should be handled using applications for multiple certification letters (see subsection D of this section).

3. All requests submitted by local governments for review and approval must contain the following minimum information:

a. A letter requesting subdivision review and certification by the locality that the subdivision package has been determined to be complete.

b. Individual site and soil evaluation reports in accordance with 12 VAC 5-615-360 for each proposed lot in the subdivision. These individual reports must be identified as to the subdivision and the proposed lot number.

c. A preliminary subdivision plat that provides the information specified in 12 VAC 5-610-360. This includes all information required by the local ordinance, and includes the following if not required by local ordinance: proposed streets, utilities, storm drainage, water supplies, easements, lot lines, existing and proposed water supplies for each proposed lot and within 200 feet of any proposed or existing sewage system, and original topographic contour lines by detail survey. The plat shall be prepared according to suggested scales and contour intervals contained in Appendix L of the Sewage Handling and Disposal Regulations.

4. Abbreviated system designs in a form approved by the division for the type of system proposed.

5. A statement in accordance with 12 VAC 5-615-70, 12 VAC 5-615-280, and 12 VAC 5-615-380 C for each proposed site certifying that the site and soil conditions and design conform to the Sewage Handling and Disposal Regulations.

Table [32]
Types of Applications

| | Single Lot Construction Permit | Single Lot Certification Letter | Multiple Lot Certification Letters | Subdivision |
|---------------------------------|-----------------------------------|------------------------------------|---------------------------------------|-------------|
| Application | X | X | X | |
| Fee | X | X | X | |
| Site Evaluation | X | X | X | X |
| Proposed Well Site | X | X | X | X |
| Construction Drawings | X | | | |
| Construction Specifications | X | | | |
| Design Calculations | X | | | |
| Abbreviated Design calculations | | X | X | X |
| Certification of Compliance | X | X | X | X |
| Local Government Request | | | | X |
| Preliminary Subdivision Plat | | | X (as necessary) | X |
| Max. Time to Process | 15 Working Days | 20 Working Days | 60 Days | 60 Days |
| Rec. Time to Process | 5 Working Days | 10 Working Days | 45 Days | 45 Days |

12 VAC 5-615-360. [No change from proposed.]

12 VAC 5-615-370. Access to information.

When requesting information from the department's official records, an AOSE/PE shall clearly and accurately identify property locations, using tax map numbers when possible, and specify the information requested on a form approved by the division. The department shall, as resources permit, provide the requested information in as timely a manner as possible, and shall in all cases comply with the Virginia Freedom of Information Act (§ 2.2-3700 et seq. of the Code of Virginia []).

12 VAC 5-615-380. [No change from proposed.]

12 VAC 5-615-390. Professional courtesy review.

A. Any AOSE/PE may request a site-specific professional courtesy review, prior to the submission of an application for a construction permit or certification letter, where he has determined that the site and soil conditions in a specific area proposed for an onsite sewage system are marginal or where he has not been able to determine with certainty that the conditions comply with the requirements of the Sewage Handling and Disposal Regulations [(12 VAC 5-610)]. A request for review shall be in a form approved by the division and shall include [written authorization from the owner giving the department permission to enter the property and] a complete evaluation report as described in 12 VAC 5-615-360, with the exception of the certification statement. In place of the certification statement required under 12 VAC 5-615-360 the AOSE/PE shall provide a brief description of the particular site and soil features or characteristics that the AOSE/PE has identified as marginal or questionable and which form the basis for the request for review and a preliminary opinion as to whether the site meets the requirements of the Sewage Handling and Disposal Regulations. Professional courtesy reviews are not intended to replace the AOSE/PE's responsibility to exercise professional judgement in determining whether a site meets the minimum requirements of the Sewage Handling and Disposal Regulations. The

department is not required to perform such reviews but may do so in its sole discretion.

B. In accordance with 12 VAC 5-615-70 B 3, the department may limit professional courtesy reviews for construction permits and certification letters. Whenever the department determines that it will not provide a requested review, it shall notify the AOSE/PE and the applicant in writing within a reasonable time. When the department elects to provide professional courtesy reviews, it shall do so in a reasonable time.

C. Any AOSE/PE may request a general (not site-specific) professional courtesy review, prior to the submission of a proposal for subdivision approval to a local government entity, where he has determined that the site and soil conditions in an area proposed for a subdivision with onsite sewage systems are marginal or where he has not been able to determine with certainty that the conditions comply with the requirements of the Sewage Handling and Disposal Regulations. A request for review shall be in a form approved by the division and shall include [written authorization from the owner giving the department permission to enter the property and] a summary evaluation report that generally comports with the requirements of 12 VAC 5-615-360, with the exception of the certification statement. In place of the certification statement required under 12 VAC 5-615-360, the AOSE/PE shall provide a brief description of the particular site and soil features or characteristics that the AOSE/PE has identified as marginal or questionable and which form the basis for the request for review and a preliminary opinion as to whether the area generally meets the requirements of the Sewage Handling and Disposal Regulations. Such requests are intended to allow the department to consult with AOSE/PEs in a nonsite-specific manner where the local health department's knowledge of general site and soil conditions and the requirements of the Sewage Handling and Disposal Regulations can assist the AOSE/PE and local governments in the planning stages of subdivision approval. Professional courtesy reviews are not intended to replace the AOSE/PE's responsibility to exercise professional judgment in determining

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whether a specific site meets the minimum requirements of the Sewage Handling and Disposal Regulations.

D. In accordance with 12 VAC 5-615-70 B 4, the department may limit professional courtesy reviews for proposed subdivisions. Whenever the department determines that it will not provide a requested review, it shall notify the AOSE/PE and the applicant in writing within a reasonable time. When the department elects to provide professional courtesy reviews, it shall do so in a reasonable time.

E. Professional courtesy reviews shall not be construed as case decisions.

12 VAC 5-615-400. [No change from proposed.]

*PART V.
CONFLICT OF INTEREST AND DISCLOSURE.*

12 VAC 5-615-410 through 12 VAC 5-615-470. [No change from proposed.]

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| <p>NOTICE: The forms used in administering 12 VAC 5-615, Authorized Onsite Soil Evaluator Regulations, are listed below. Any amended or added forms are reflected in the listing and are published following the listing.</p> |
|--|

FORMS

Application to Become an Authorized Onsite Soil Evaluator, eff 9/01.

Renewal Application-Authorized Onsite Soil Evaluator, eff. 9/01.

[Continuing Education Classes attended in the previous two years (eff. 7/02).]

Application to Become an Authorized Onsite Soil Evaluator

| | |
|-------------------------------------|-------------------------------|
| Application Type (check one) | |
| <input type="checkbox"/> | CPSS |
| <input type="checkbox"/> | Person with 5 yrs. experience |
| <input type="checkbox"/> | Person with 2 yrs. experience |
| <input type="checkbox"/> | VDH Employee |

If a question is not applicable, mark "N/A". All blocks must be completed. Please type your responses.

| | |
|--|---|
| Name (Last, first, middle): | Date of Application: |
| Home Address: (must include a street address) | Business Address |
| Phone (home): | Phone (work): |
| Email address: | Other: |
| Fax: | Mobile: |
| Drivers License Number: _____ | Date of Birth: |
| Are you a Virginia Certified Professional Soil Scientist? Yes ___ No ___ | CPSS registration number: _____ Please attach a copy of your CPSS Registration. |
| How many years experience do you have evaluating site and soil conditions for onsite sewage systems in Virginia? ___ years | Have you attached two site evaluations that comply with the requirements described in GMP #99? Yes ___ No ___ |
| Have you attached three letters of reference that comply with the requirements of GMP #99? Yes ___ No ___ | Have you attached two system designs that comply with the requirements of GMP #99? Yes ___ No ___ |

I certify that the information provided on this application is true. Further, I understand that providing false or misleading information or suppressing information on this application may result in denial of my application or the suspension or revocation of my standing as an Authorized Onsite Soil Evaluator if my application has been approved. I authorize the Department to conduct reference checks as necessary to evaluate my application.

Signed _____ Date _____

Applications should be submitted to: The Division of Onsite Sewage and Water Services
PO Box 2448
1500 E. Main St., Room 117
Richmond, VA 23218. **Attention AOSE Application**

Please enclose a check for the application fee of \$100 (made payable to the Commonwealth of Virginia)

Department Use: AOSE Test results: _____
AOSE Training completed _____

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Renewal Application Authorized Onsite Soil Evaluator

If a question is not applicable, mark "N/A". All blocks must be completed. Please write legibly or type.

| | |
|-----------------------------|----------------------|
| Name (Last, first, middle): | Date of Application: |
|-----------------------------|----------------------|

| | |
|---|--|
| Home Address: (please include a street address) | Business Address: |
| Phone (home): | Phone (work): |
| Email address: | Other: |
| Fax: | Mobile: |
| Are you a Virginia Certified Professional Soil Scientist? Yes ____ No ____ | CPSS registration number: _____ Please attach a copy of your CPSS Registration. |

I certify that the information provided on this application is true. Further, I understand that providing false or misleading information or suppressing information on this application may result in denial of my application or the suspension or revocation of my standing as an Authorized Onsite Soil Evaluator. I authorize the Department to conduct checks as necessary to evaluate the information contained on this form.

Signed _____ Date _____

Applications should be submitted to: Division of Onsite Sewage and Water Services
1500 E. Main Street, Room 115
Richmond, VA 23219 **Attention: AOSE Application**

It shall be the responsibility of the AOSE to update the above information as necessary. Please enclose a check for the application renewal fee of \$100.00 (made payable to the Commonwealth of Virginia).

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Continuing Education Classes attended in the previous two years.

| Number of CEUs | Number of hours | Course Title | Offered By | Date Taken |
|----------------|-----------------|--------------|------------|------------|
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| | | | | |

Attach additional information as necessary.

TOTAL CEU's _____

TOTAL HOURS _____

7/02

VA.R. Doc. No. R00-225; Filed April 30, 2002, 3:08 p.m.

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DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

REGISTRAR'S NOTICE: The following regulatory action is exempt from the Administrative Process Act in accordance with § 2.2-4006 A 4 a of the Code of Virginia, which excludes regulations that are necessary to conform to changes in Virginia statutory law where no agency discretion is involved. The Department of Medical Assistance Services will receive, consider and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: **12 VAC 30-40. Eligibility Conditions and Requirements** (amending **12 VAC 30-40-220, 12 VAC 30-40-280, 12 VAC 30-40-290, and 12 VAC 30-40-345.**)

Statutory Authority: § 32.1-325 of the Code of Virginia.

Effective Date: July 1, 2002.

Summary:

The amendments specify that the medically needy income limits will be adjusted annually to reflect increases in the Consumer Price Index and thus avoid the necessity of filing a regulatory package each year to reflect the actual change.

The actual medically needy income limits for a current year can be obtained by contacting any local Department of Social Services in the Commonwealth.

The amendments provide for an automatic increase in the AFDC income limits in the state plan to reflect the annual increase in the Consumer Price Index. The 2001 increase in the Consumer Price Index was 2.6%, which will be reflected in the July 2002 income limits. Because federal financial participation requires that the Medically Needy Income Limits cannot exceed 133-1/3% of the AFDC income limits, it is necessary to increase the standards of assistance at the same time that the medically needy income limits are increased.

Also, the amendments expand the purposes for which an applicant or recipient can set aside funds and the types of accounts in which the funds can be placed.

Agency Contact: Pat Sykes, Manager, Policy Division, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23235, telephone (804) 786-7958, FAX (804) 786-7958 or e-mail psykes@dmass.state.va.us.

12 VAC 30-40-220. Income eligibility levels.

A. Mandatory Categorically Needy

1. AFDC-related groups other than poverty level pregnant women and infants.

| Family Size | Need Standard | Payment Standard | Maximum Payment Amounts |
|---|----------------|------------------|-------------------------|
| | See Table 1 | See Table 2 | |
| STANDARDS OF ASSISTANCE (adjusted to reflect increases in the medically needy income limits at 12 VAC 30-40-220-E Increased annually by the increase in the Consumer Price Index) | | | |
| GROUP I | | | |
| Size of Assistance Unit | Table 1 (100%) | Table 2 (90%) | |
| 1 | \$151.11 | \$135.58 | |
| 2 | 237.01 | 214.24 | |
| 3 | 305.32 | 274.27 | |
| 4 | 370.53 | 333.27 | |
| 5 | 436.77 | 393.30 | |
| 6 | 489.55 | 441.94 | |
| 7 | 553.72 | 498.87 | |
| 8 | 623.07 | 559.93 | |
| 9 | 679.99 | 611.68 | |
| 10 | 743.13 | 669.64 | |
| Each person above 10 | 63.13 | 57.96 | |
| MAXIMUM REIMBURSABLE PAYMENT \$403 | | | |

| GROUP II | | |
|-------------------------|----------------|---------------|
| Size of Assistance Unit | Table 1 (100%) | Table 2 (90%) |
| 1 | \$180.09 | \$162.49 |
| 2 | 265.99 | 239.08 |
| 3 | 333.27 | 301.18 |
| 4 | 399.51 | 359.14 |
| 5 | 472.99 | 423.35 |
| 6 | 526.81 | 474.03 |
| 7 | 589.95 | 529.92 |
| 8 | 658.26 | 592.02 |
| 9 | 716.22 | 644.80 |
| 10 | 780.39 | 701.73 |
| Each person above 10 | 63.13 | 57.96 |

MAXIMUM REIMBURSABLE PAYMENT \$435

| GROUP III | | |
|-------------------------|----------------|---------------|
| Size of Assistance Unit | Table 1 (100%) | Table 2 (90%) |
| 1 | \$251.50 | \$227.70 |
| 2 | 338.44 | 304.29 |
| 3 | 406.75 | 366.39 |
| 4 | 472.99 | 424.35 |
| 5 | 560.97 | 505.08 |
| 6 | 613.75 | 552.69 |
| 7 | 677.92 | 610.65 |
| 8 | 745.23 | 672.75 |
| 9 | 806.26 | 725.53 |
| 10 | 868.33 | 781.42 |
| Each person above 10 | 63.13 | 57.96 |

MAXIMUM REIMBURSABLE PAYMENT \$518

2. Pregnant women and infants under 1902(a)(10)(i)(IV) of the Act:

Effective April 1, 1990, based on 133% of the official federal income poverty level.

3. Children under § 1902(a)(10)(i)(VI) of the Act (children who have attained age 1 but have not attained age 6), the income eligibility level is 133% of the federal poverty level (as revised annually in the Federal Register) for the size family involved.

4. For children under § 1902(a)(10)(i)(VII) of the Act (children who were born after September 30, 1983, and have attained age 6 but have not attained age 19), the income eligibility level is 100% of the federal poverty level (as revised annually in the Federal Register) for the size family involved.

B. Treatment of COLA for groups with income related to federal poverty level.

1. If an individual receives a Title II benefit, any amount attributable to the most recent increase in the monthly insurance benefit as a result of a Title II COLA is not counted as income during a "transition period" beginning with January, when the Title II benefit for December is received, and ending with the last day of the month following the month of publication of the revised annual federal poverty level.

2. For individuals with Title II income, the revised poverty levels are not effective until the first day of the month following the end of the transition period.

3. For individuals not receiving Title II income, the revised poverty levels are effective no later than the beginning of the month following the date of publication.

C. Qualified Medicare beneficiaries with incomes related to federal poverty level.

The levels for determining income eligibility for groups of qualified Medicare beneficiaries under the provisions of § 1905(p)(2)(A) of the Act are as follows:

Section 1902(f) states which as of January 1, 1987, used income standards more restrictive than SSI. (VA did not apply a more restrictive income standard as of January 1, 1987.)

Based on the following percentage of the official federal income poverty level:

Effective Jan. 1, 1989: 85%

Effective Jan. 1, 1990: 90% (no more than 100)

Effective Jan. 1, 1991: 100% (no more than 100)

Effective Jan. 1, 1992: 100%

D. Aged and disabled individuals described in § 1902(m)(1) of the Act; Level for determining income eligibility for aged and

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disabled persons described in § 1902(m)(1) of the Act is 80% of the official federal income poverty level (as revised annually in the Federal Register) for the size family involved.

E. Income levels - medically needy. *(Increased annually the increase in the Consumer Price Index but no higher than the level permitted to claim federal financial participation.)*

1. The following income levels ~~(as adjusted annually by the increase in the CPI)~~ are applicable to all groups, urban and rural.

2. The agency has methods for excluding from its claim for FFP payments made on behalf of individuals whose income exceeds these limits.

| (1) | (2) | | | (3) |
|----------------------------------|--|------------|------------|---|
| Family Size | Net income level protected for maintenance for 12 months | | | Amount by which Column 2 exceeds limits specified in 42 CFR 435.1007 ¹ |
| | Group I | Group II | Group III | |
| 1 | \$2,691.00 | \$3,105.00 | \$4,036.50 | \$0 |
| 2 | \$3,519.00 | \$3,824.00 | \$4,867.00 | \$0 |
| 3 | \$4,036.50 | \$4,450.50 | \$5,485.50 | \$0 |
| 4 | \$4,554.00 | \$4,968.00 | \$6,003.00 | \$0 |
| 5 | \$5,071.50 | \$5,485.50 | \$6,520.50 | \$0 |
| 6 | \$5,589.00 | \$6,003.00 | \$7,038.00 | \$0 |
| 7 | \$6,106.50 | \$6,520.50 | \$7,555.50 | \$0 |
| 8 | \$6,727.50 | \$7,141.50 | \$8,073.00 | \$0 |
| 9 | \$7,348.50 | \$7,762.50 | \$8,797.50 | \$0 |
| 10 | \$8,073.00 | \$8,487.00 | \$9,418.50 | \$0 |
| For each additional person, add: | \$695.52 | \$695.52 | \$695.52 | \$0 |

¹ As authorized in § 4718 of OBRA '90.

| Grouping of Localities | | Giles | Shenandoah |
|------------------------|----------------|---------------|--------------|
| GROUP I | | Gloucester | Smyth |
| Counties | | Goochland | Southampton |
| Accomack | King George | Grayson | Spotsylvania |
| Alleghany | King and Queen | Greene | Stafford |
| Amelia | King William | Greensville | Surry |
| Amherst | Lancaster | Halifax | Sussex |
| Appomattox | Lee | Hanover | Tazewell |
| Bath | Louisa | Henry | Washington |
| Bedford | Lunenburg | Highland | Westmoreland |
| Bland | Madison | Isle of Wight | Wise |
| Botetourt | Matthews | James City | Wythe |
| Brunswick | Mecklenburg | Cities | York |
| Buchanan | Middlesex | Bristol | Franklin |
| Buckingham | Nelson | Buena Vista | Galax |
| Campbell | New Kent | Clifton Forge | Norton |
| Caroline | Northampton | Danville | Poquoson |
| Carroll | Northumberland | Emporia | Suffolk |
| Charles City | Nottoway | GROUP II | |
| Charlotte | Orange | Counties | |
| Clarke | Page | Albemarle | Loudoun |
| Craig | Patrick | Augusta | Roanoke |
| Culpeper | Pittsylvania | Chesterfield | Rockingham |
| Cumberland | Powhatan | Henrico | Warren |
| Dickenson | Prince Edward | Cities | |
| Dinwiddie | Prince George | Chesapeake | Portsmouth |
| Essex | Pulaski | Covington | Radford |
| Fauquier | Rappahannock | Harrisonburg | Richmond |
| Floyd | Richmond | Hopewell | Roanoke |
| Fluvanna | Rockbridge | Lexington | Salem |
| Franklin | Russell | Lynchburg | Staunton |
| Frederick | Scott | | |

| | |
|--------------|----------------|
| Martinsville | Virginia Beach |
| Newport News | Williamsburg |
| Norfolk | Winchester |
| Petersburg | |

GROUP III

Counties

| | |
|-----------|----------------|
| Arlington | Montgomery |
| Fairfax | Prince William |

Cities

| | |
|------------------|----------------|
| Alexandria | Fredericksburg |
| Charlottesville | Hampton |
| Colonial Heights | Manassas |
| Fairfax | Manassas Park |
| Falls Church | Waynesboro |

12 VAC 30-40-280. More liberal income disregards.

A. For children covered under §§ 1902(a)(10)(A)(i)(III) and 1905(n) of the Social Security Act, the Commonwealth of Virginia will disregard one dollar plus an amount equal to the difference between 100% of the AFDC payment standard for the same family size and 100% of the Federal Poverty Level for the same family size as updated annually in the Federal Register.

B. For ADC-related cases, both categorically and medically needy, any individual or family applying for or receiving assistance shall be granted an income exemption consistent with the Act (§§ 1902(a)(10)(A)(i)(III), (IV), (VI), (VII); §§ 1902(a)(10)(A)(ii)(VIII), (IX); § 1902(a)(10)(C)(i)(III)). Any interest earned on one interest-bearing savings or investment account per assistance unit not to exceed \$5,000 at a financial institution, if the applicant, applicants, recipient or recipients designate that the account is reserved for the purpose of paying for tuition, books, and incidental expenses at any elementary, secondary or vocational school or any college or university, or for making down payment on a primary residence or for business incubation purposes related to self-sufficiency, shall be exempt when determining eligibility for medical assistance for so long as the funds and interest remain on deposit in the account. For purposes of this section, "business incubation" means the initial establishment of a commercial operation owned by a member of the Medicaid assistance unit (§ 63.1-110 of the Code of Virginia) "purposes related to self-sufficiency" shall include, but are not limited to, (i) paying for tuition, books, and incidental expenses at any elementary, secondary, or vocational school, or any college or university; (ii) for making down payment on a primary residence; or (iii) for establishment of a commercial operation that is owned by a member of the Medicaid assistance unit.

12 VAC 30-40-290. More liberal methods of treating resources under § 1902(r)(2) of the Act.

§ 1902(f) State

A. Resources to meet burial expenses. Resources set aside to meet the burial expenses of an applicant/recipient or that individual's spouse are excluded from countable assets. In determining eligibility for benefits for medically needy individuals, disregarded from countable resources is an amount not in excess of \$3,500 for the individual and an amount not in excess of \$3,500 for his spouse when such

resources have been set aside to meet the burial expenses of the individual or his spouse. The amount disregarded shall be reduced by:

1. The face value of life insurance on the life of an individual owned by the individual or his spouse if the cash surrender value of such policies has been excluded from countable resources; and

2. The amount of any other revocable or irrevocable trust, contract, or other arrangement specifically designated for the purpose of meeting the individual's or his spouse's burial expenses.

B. Life rights. Life rights to real property are not counted as a resource.

C. Reasonable effort to sell.

1. For purposes of this section, "current market value" is defined as the current tax assessed value. If the property is listed by a realtor, then the realtor may list it at an amount higher than the tax assessed value. In no event, however, shall the realtor's list price exceed 150% of the assessed value.

2. A reasonable effort to sell is considered to have been made:

- a. As of the date the property becomes subject to a realtor's listing agreement if:

- (1) It is listed at a price at current market value; and

- (2) The listing realtor verifies that it is unlikely to sell within 90 days of listing given the particular circumstances involved (e.g., owner's fractional interest; zoning restrictions; poor topography; absence of road frontage or access; absence of improvements; clouds on title, right of way or easement; local market conditions); or

- b. When at least two realtors refuse to list the property. The reason for refusal must be that the property is unsaleable at current market value. Other reasons for refusal are not sufficient; or

- c. When the applicant has personally advertised his property at or below current market value for 90 days by use of a "Sale By Owner" sign located on the property and by other reasonable efforts, such as newspaper advertisements, or reasonable inquiries with all adjoining landowners or other potential interested purchasers.

3. Notwithstanding the fact that the recipient made a reasonable effort to sell the property and failed to sell it, and although the recipient has become eligible, the recipient must make a continuing reasonable effort to sell by:

- a. Repeatedly renewing any initial listing agreement until the property is sold. If the list price was initially higher than the tax-assessed value, the listed sales price must be reduced after 12 months to no more than 100% of the tax-assessed value.

- b. In the case where at least two realtors have refused to list the property, the recipient must personally try to sell the property by efforts described in subdivision 2 c of this subsection for 12 months.

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c. In the case of a recipient who has personally advertised his property for a year without success (the newspaper advertisements and "for sale" sign do not have to be continuous; these efforts must be done for at least 90 days within a 12-month period), the recipient must then:

(1) Subject his property to a realtor's listing agreement at price or below current market value; or

(2) Meet the requirements of subdivision 2 b of this subsection which are that the recipient must try to list the property and at least two realtors refuse to list it because it is unsaleable at current market value; other reasons for refusal to list are not sufficient.

4. If the recipient has made a continuing effort to sell the property for 12 months, then the recipient may sell the property between 75% and 100% of its tax assessed value and such sale shall not result in disqualification under the transfer of property rules. If the recipient requests to sell his property at less than 75% of assessed value, he must submit documentation from the listing realtor, or knowledgeable source if the property is not listed with a realtor, that the requested sale price is the best price the recipient can expect to receive for the property at this time. Sale at such a documented price shall not result in disqualification under the transfer of property rules. The proceeds of the sale will be counted as a resource in determining continuing eligibility.

5. Once the applicant has demonstrated that his property is unsaleable by following the procedures in subdivision 2 of this subsection, the property is disregarded in determining eligibility starting the first day of the month in which the most recent application was filed, or up to three months prior to this month of application if retroactive coverage is requested and the applicant met all other eligibility requirements in the period. A recipient must continue his reasonable efforts to sell the property as required in subdivision 3 of this subsection.

D. Automobiles. Ownership of one motor vehicle does not affect eligibility. If more than one vehicle is owned, the individual's equity in the least valuable vehicle or vehicles must be counted. The value of the vehicles is the wholesale value listed in the National Automobile Dealers Official Used Car Guide (NADA) Book, Eastern Edition (update monthly). In the event the vehicle is not listed, the value assessed by the locality for tax purposes may be used. The value of the additional motor vehicles is to be counted in relation to the amount of assets that could be liquidated that may be retained.

E. Life, retirement, and other related types of insurance policies. Life, retirement, and other related types of insurance policies with face values totaling \$1,500 or less on any one person 21 years old and over are not considered resources. When the face values of such policies of any one person exceeds \$1,500, the cash surrender value of the policies is counted as a resource.

F. Resource exemption for Aid to Dependent Children categorically and medically needy (the Act §§ 1902(a)(10)(A)(i)(III), (IV), (VI), (VII); §§ 1902(a)(10)(A)(ii)(VIII), (IX); § 1902(a)(10)(C)(i)(III)). For ADC-related cases, both categorically and medically needy, any individual or family applying for or receiving assistance

may have or establish one interest-bearing savings or *investment* account per assistance unit not to exceed \$5,000 ~~at a financial institution~~ if the applicant, applicants, recipient or recipients designate that the account is reserved for ~~one of the following purposes: (i) paying for tuition, books, and incidental expenses at any elementary, secondary or vocational school or any college or university; (ii) making down payment on a primary residence; or (iii) business incubation purposes related to self-sufficiency.~~ Any funds deposited in the account shall be exempt when determining eligibility for medical assistance for so long as the funds and interest remain on deposit in the account. Any amounts withdrawn and used for ~~any of the purposes stated in this section related to self-sufficiency shall be exempt. For purposes of this section, "business incubation" shall mean the initial establishment of a commercial operation which is owned by a member of the Medicaid assistance unit. The net worth of any business owned by a member of the assistance unit shall be exempt from consideration so long as the net worth of the business is less than \$5,000 purposes related to self-sufficiency shall include, but are not limited to, (i) paying for tuition, books, and incidental expenses at any elementary, secondary, or vocational school, or any college or university; (ii) for making down payment on a primary residence; or (iii) for establishment of a commercial operation that is owned by a member of the medical assistance unit.~~

G. Disregard of resources. The Commonwealth of Virginia will disregard all resources for qualified children covered under §§ 1902(a)(10)(A)(i)(III) and 1905(n) of the Social Security Act.

12 VAC 30-40-345. Eligibility under § 1931 of the Act.

A. The state covers low-income families and children under § 1931 of the Act as follows:

AFDC children age 18 who are full-time students in a secondary school or in the equivalent level of vocational or technical training.

B. In determining eligibility for Medicaid, the agency uses the AFDC standards and methodologies in effect as of July 16, 1996, without modification, for individuals who do not receive TANF benefits.

C. *In determining eligibility for Medicaid, the agency uses the AFDC standards and methodologies in effect as of July 16, 1996, with the following modifications.*

1. *The agency applies higher income standards than those in effect as of July 16, 1996, increased by no more than the percentage increases in the CPI-U since July 16, 1996. The agency increases the July 16, 1996, income standards shown in 12 VAC 30-40-220 by the annual increase in the CPI beginning July 1, 2001.*

2. *The agency uses less restrictive income or resource methodologies than those in effect as of July 16, 1996. Any applicant or recipient may have or establish one savings or investment account not to exceed \$5,000 if the applicant or recipient designates that the account is reserved for purposes related to self-sufficiency. Any funds deposited in the account and any interest earned on or appreciation in the value of the funds shall be exempt when determining*

eligibility for as long as the funds and interest on or appreciation in value of remain in the account. Any amounts withdrawn and used for purposes related to self-sufficiency shall be exempt. For purposes of this section, "purposes related to self-sufficiency" shall include, but is not limited to, paying for tuition, books and incidental expenses at any elementary, secondary or vocational school or any college or university; making down payment on a primary residence; or establishing a commercial operation that is owned by a member of the Medicaid assistance unit. The income or resource methodologies that the less restrictive methodologies replace are as follows:

a. *Resources.* Any individual or family applying for or receiving assistance may have or establish one interest-bearing savings or investment account per assistance unit not to exceed \$5,000 at a financial institution if the applicant or recipient designates that the account is reserved for one of the following purposes: (i) paying for tuition, books, and incidental expenses at any elementary, secondary or vocational school or any college or university; (ii) making down payment on a primary residence; or (iii) business incubation. Any funds deposited in the account shall be exempt when determining eligibility for medical assistance for so long as the funds and interest remain on deposit in the account. Any amounts withdrawn and used for any of the purposes stated in this section shall be exempt. For purposes of this section, "business incubation" shall mean the initial establishment of a commercial operation that is owned by a member of the Medicaid assistance unit. The net worth of any business owned by a member of the assistance unit shall be exempt from consideration as long as the net worth of the business is less than \$5,000.

b. *Income.* Any interest or appreciation earned on one interest-bearing savings account per medical assistance unit not to exceed \$5,000 at a financial institution, if the applicant or recipient designates that the account is reserved for the purpose of paying for tuition, books, and incidental expenses at any elementary, secondary or vocational school or any college or university, or for making down payment on a primary residence or for business incubation, shall be exempt when determining eligibility for medical assistance for as long as the funds and interest remain on deposit in the account. For purposes of this section, "business incubation" means the initial establishment of a commercial operation owned by a member of the Medicaid assistance unit.

D. The agency continues to apply the following waivers of the provisions of Part A of Title IV in effect as of July 16, 1996, or submitted prior to August 22, 1996, and approved by the secretary on or before July 1, 1997. For individuals who receive TANF benefits and meet the requirements of Virginia's § 1115 waiver for the Virginia Independence Program, the agency continues to apply the following waivers of the provisions of Part A of Title IV in effect as of July 16, 1996, or submitted prior to August 22, 1996, and approved by the secretary on or before July 1, 1997. The waiver contains the following more liberal income disregards:

1. Earned income will be disregarded so long as the earnings plus the AFDC benefits are equal to or less than 100% of the Federal Income Poverty Guidelines. For any month in which earnings plus the AFDC standard of payment for the family size exceed the Federal Poverty Income Guidelines for a family of the same size, earned income above 100% of the Federal Poverty Income Guidelines shall be counted.

2. One automobile valued at \$7,500.

These waivers will apply only to TANF cash assistance recipients. These waivers will be continued only for so long as eligibility for TANF was established under the welfare reform demonstration project for which these waivers were originally approved.

VA.R. Doc. No. R02-161; Filed April 22, 2002, 11:26 a.m.

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REGISTRAR'S NOTICE: The Department of Medical Assistance Services is claiming an exemption from the Administrative Process Act in accordance with § 2.2-4006 A 3 of the Code of Virginia, which excludes regulations that consist only of changes in style or form or corrections of technical errors. The Department of Medical Assistance Services will receive, consider and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: 12 VAC 30-50. Amount, Duration, and Scope of Medical and Remedial Services (amending 12 VAC 30-50-190.)

Statutory Authority: § 32.1-325 of the Code of Virginia.

Effective Date: July 1, 2002.

Summary:

The amendment expands the pended claims review process currently in place to apply to nonurgent treatment with the exception of comprehensive orthodontic care. Not having to obtain prior authorization for nonurgent treatment services allows the dental provider flexibility to provide such services without having to go through the preauthorization process.

Agency Contact: Steve Riggs, DDS, Dental Consultant, Program Operations, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23235, telephone (804) 225-4393.

12 VAC 30-50-190. Dental services.

A. Dental services are limited to recipients under 21 years of age in fulfillment of the treatment requirements under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program and defined as routine diagnostic, preventive, or restorative procedures necessary for oral health provided by or under the direct supervision of a dentist in accordance with the State Dental Practice Act.

B. Initial, periodic, and emergency examinations; required radiography necessary to develop a treatment plan; patient education; dental prophylaxis; fluoride treatments; dental

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sealants; routine amalgam and composite restorations; crown recementation; pulpotomies; emergency endodontics for temporary relief of pain; pulp capping; sedative fillings; therapeutic apical closure; topical palliative treatment for dental pain; removal of foreign body; simple extractions; root recovery; incision and drainage of abscess; surgical exposure of the tooth to aid eruption; sequestrectomy for osteomyelitis; and oral antral fistula closure are dental services covered without preauthorization by the state agency.

C. All covered dental services not referenced above require preauthorization *or prepayment review* by the state agency. The following services are also covered through preauthorization: medically necessary full banded orthodontics, for handicapping malocclusions, minor tooth guidance or repositioning appliances, complete and partial dentures, surgical preparation (alveoloplasty) for prosthetics, single permanent crowns, and bridges. The following service is not covered: routine bases under restorations and inhalation analgesia.

D. The state agency may place appropriate limits on a service based on medical necessity, for utilization control, or both. Examples of service limitations are: examinations, prophylaxis, fluoride treatment (once/six months); space maintenance appliances; bitewing x-ray -- two films (once/~~twelve~~ 12 months); routine amalgam and composite restorations (once/three years); dentures (once ~~per 5~~ five years); extractions, orthodontics, tooth guidance appliances, permanent crowns and bridges, endodontics, patient education and sealants (once).

E. Limited oral surgery procedures, as defined and covered under Title XVIII (Medicare), are covered for all recipients, and also require preauthorization by the state agency.

VA.R. Doc. No. R02-162; Filed April 22, 2002, 11:27 a.m.

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| <p>REGISTRAR'S NOTICE: The following regulatory action is exempt from the Administrative Process Act in accordance with § 2.2-4006 A 4 a of the Code of Virginia, which excludes regulations that are necessary to conform to changes in Virginia statutory law where no agency discretion is involved. The Department of Medical Assistance Services will receive, consider and respond to petitions by any interested person at any time with respect to reconsideration or revision.</p> |
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Title of Regulation: 12 VAC 30-50. Amount, Duration, and Scope of Medical and Remedial Care and Services (amending 12 VAC 30-50-210).

Statutory Authority: § 32.1-325 of the Code of Virginia.

Effective Date: July 1, 2002.

Summary:

The amendment limits prescriptions to provide for a maximum of a 34-day supply per prescription per patient.

Agency Contact: Marianne Rollings, Pharmacist, Division of Program Operations, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219,

telephone (804) 225-4268 or FAX (804) 225-4393, e-mail mrollings@dmas.state.va.us.

12 VAC 30-50-210. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

A. Prescribed drugs.

1. Drugs for which Federal Financial Participation is not available, pursuant to the requirements of § 1927 of the Social Security Act (OBRA 90 § 4401), shall not be covered.

2. Nonlegend drugs shall be covered by Medicaid in the following situations:

- Insulin, syringes, and needles for diabetic patients;
- Diabetic test strips for Medicaid recipients under 21 years of age;
- Family planning supplies;
- Designated categories of nonlegend drugs for Medicaid recipients in nursing homes; and
- Designated drugs prescribed by a licensed prescriber to be used as less expensive therapeutic alternatives to covered legend drugs.

3. Legend drugs are covered *for a maximum of a 34-day supply per prescription per patient* with the exception of the drugs or classes of drugs identified in 12 VAC 30-50-520. FDA-approved drug therapies and agents for weight loss, when preauthorized, will be covered for recipients who meet the strict disability standards for obesity established by the Social Security Administration in effect on April 7, 1999, and whose condition is certified as life threatening, consistent with Department of Medical Assistance Services' medical necessity requirements, by the treating physician. *For prescription orders for which quantity exceeds a 34-day supply, refills may be dispensed in sufficient quantity to fulfill the prescription order within the limits of federal and state laws and regulations.*

4. Notwithstanding the provisions of § 32.1-87 of the Code of Virginia, and in compliance with the provision of § 4401 of the Omnibus Reconciliation Act of 1990, § 1927(e) of the Social Security Act as amended by OBRA 90, and pursuant to the authority provided for under § 32.1-325 A of the Code of Virginia, prescriptions for Medicaid recipients for multiple source drugs subject to 42 CFR 447.332 shall be filled with generic drug products unless the physician or other practitioners so licensed and certified to prescribe drugs certifies in his own handwriting "brand necessary" for the prescription to be dispensed as written.

5. New drugs shall be covered in accordance with the Social Security Act § 1927(d) (OBRA 90 § 4401).

6. The number of refills shall be limited pursuant to § 54.1-3411 of the Drug Control Act.

7. Drug prior authorization.

a. Definitions. The following words and terms used in these regulations shall have the following meaning, unless the context clearly indicates otherwise:

"Board" means the Board for Medical Assistance Services.

"Committee" means the Medicaid Prior Authorization Advisory Committee.

"Department" means the Department of Medical Assistance Services.

"Director" means the Director of Medical Assistance Services.

"Drug" shall have the same meaning, unless the context otherwise dictates or the board otherwise provides by regulation, as provided in the Drug Control Act (§ 54.1-3400 et seq. of the Code of Virginia).

b. Medicaid Prior Authorization Advisory Committee; membership. The Medicaid Prior Authorization Committee shall consist of 11 members to be appointed by the board. Five members shall be physicians, at least three of whom shall care for a significant number of Medicaid patients; four shall be pharmacists, two of whom shall be community pharmacists; one member shall be a consumer of mental health services; and one shall be a Medicaid recipient.

(1) A quorum for action of the committee shall consist of six members.

(2) The members shall serve at the pleasure of the board; vacancies shall be filled in the same manner as the original appointment.

(3) The board shall consider nominations made by the Medical Society of Virginia, the Old Dominion Medical Society, the Psychiatric Society of Virginia, the Virginia Pharmaceutical Association, the Virginia Alliance for the Mentally Ill, and the Virginia Mental Health Consumers Association when making appointments to the committee.

(4) The committee shall elect its own officers, establish its own procedural rules, and meet as needed or as called by the board, the director, or any two members of the committee. The department shall provide appropriate staffing to the committee.

c. Duties of the committee.

(1) The committee shall make recommendations to the board regarding drugs or categories of drugs to be subject to prior authorization, prior authorization requirements for prescription drug coverage and any subsequent amendments to or revisions of the prior authorization requirements. The board may accept or reject the recommendations in whole or in part, and may amend or add to the recommendations, except that the board may not add to the recommendation of drugs and categories of drugs to be subject to prior authorization.

(2) In formulating its recommendations to the board, the committee shall not be deemed to be formulating regulations for the purposes of the Administrative Process Act (§ 2.2-4000 et seq.). The committee shall, however, conduct public hearings prior to making recommendations to the board. The committee shall give 30 days' written notice by mail of the time and place of its hearings and meetings to any manufacturer whose product is being reviewed by the committee and to those manufacturers who request of the committee in writing that they be informed of such hearings and meetings. These persons shall be afforded a reasonable opportunity to be heard and present information. The committee shall give 30 days' notice of such public hearings to the public by publishing its intention to conduct hearings and meetings in the Calendar of Events of The Virginia Register of Regulations and a newspaper of general circulation located in Richmond.

(3) In acting on the recommendations of the committee, the board shall conduct further proceedings under the Administrative Process Act.

d. Prior authorization of prescription drug products; coverage.

(1) The committee shall review prescription drug products to recommend prior authorization under the state plan. This review may be initiated by the director, the committee itself, or by written request of the board. The committee shall complete its recommendations to the board within no more than six months from receipt of any such request.

(2) Coverage for any drug requiring prior authorization shall not be approved unless a prescribing physician obtains prior approval of the use in accordance with regulations promulgated by the board and procedures established by the department.

(3) In formulating its recommendations to the board, the committee shall consider the potential impact on patient care and the potential fiscal impact of prior authorization on pharmacy, physician, hospitalization and outpatient costs. Any proposed regulation making a drug or category of drugs subject to prior authorization shall be accompanied by a statement of the estimated impact of this action on pharmacy, physician, hospitalization and outpatient costs.

(4) The committee shall not review any drug for which it has recommended or the board has required prior authorization within the previous 12 months, unless new or previously unavailable relevant and objective information is presented.

(5) Confidential proprietary information identified as such by a manufacturer or supplier in writing in advance and furnished to the committee or the board according to this subsection shall not be subject to the disclosure requirements of the Virginia Freedom of Information Act (§ 2.2-3700 et seq. of the Code of Virginia). The board shall establish by regulation the

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means by which such confidential proprietary information shall be protected.

e. Immunity. The members of the committee and the board and the staff of the department shall be immune, individually and jointly, from civil liability for any act, decision, or omission done or made in performance of their duties pursuant to this subsection while serving as a member of such board, committee, or staff provided that such act, decision, or omission is not done or made in bad faith or with malicious intent.

f. Annual report to joint commission. The committee shall report annually to the Joint Commission on Health Care regarding its recommendations for prior authorization of drug products.

8. Coverage of home infusion therapy. This service shall be covered consistent with the limits and requirements set out within home health services (12 VAC 30-50-160). Multiple applications of the same therapy (e.g., two antibiotics on the same day) shall be covered under one service day rate of reimbursement. Multiple applications of different therapies (e.g., chemotherapy, hydration, and pain management on the same day) shall be a full service day rate methodology as provided in pharmacy services reimbursement.

B. Dentures. Dentures are provided only as a result of EPSDT and subject to medical necessity and preauthorization requirements specified under Dental Services.

C. Prosthetic devices.

1. Prosthetic services shall mean the replacement of missing arms, legs, eyes, and breasts and the provision of any internal (implant) body part. Nothing in this regulation shall be construed to refer to orthotic services or devices or organ transplantation services.

2. Artificial arms and legs, and their necessary supportive attachments, implants and breasts are provided when prescribed by a physician or other licensed practitioner of the healing arts within the scope of their professional licenses as defined by state law. This service, when provided by an authorized vendor, must be medically necessary and preauthorized for the minimum applicable component necessary for the activities of daily living.

3. Eye prostheses are provided when eyeballs are missing regardless of the age of the recipient or the cause of the loss of the eyeball. Eye prostheses are provided regardless of the function of the eye.

D. Eyeglasses. Eyeglasses shall be reimbursed for all recipients younger than 21 years of age according to medical necessity when provided by practitioners as licensed under the Code of Virginia.

VA.R. Doc. No. R02-167; Filed April 30, 2002, 8:05 a.m.

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REGISTRAR'S NOTICE: The following regulatory action is exempt from the Administrative Process Act in accordance with (i) § 2.2-4006 A 3 of the Code of Virginia, which excludes regulations that consist only of changes in style or form or

corrections of technical errors and (ii) § 2.2-4006 A 4 c of the Code of Virginia, which excludes regulations that are necessary to meet the requirements of federal law or regulations provided such regulations do not differ materially from those required by federal law or regulation. The Department of Medical Assistance Services will receive, consider and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: 12 VAC 30-60. Standards Established and Methods Used to Assure High Quality of Care (amending 12 VAC 30-60-300; adding 12 VAC 30-60-303, 12 VAC 30-60-307, 12 VAC 30-60-312, 12 VAC 30-60-316 and 12 VAC 30-60-318).

Statutory Authority: 32.1-325 of the Code of Virginia.

Effective Date: June 20, 2002.

Summary:

The amendments remove the prenursing facility criteria for evaluating individuals who may need community-based services to delay the need for nursing facility placement. Currently, the State Plan contains two sets of criteria: one for nursing facility placement (nursing facility criteria), and a separate set of criteria (prenursing criteria) for admission to the home and community-based services. Since DMAS' adoption of these two sets of criteria and federal approval of them, the federal regulations were modified so that only one set of criteria can be used to evaluate the appropriate level of care for a recipient. The removal of this text is necessary in order for the State Plan to conform to current federal regulations. Failure to establish one set of criteria for nursing facility placement and admission to the home and community-based services program could result in the loss of Federal Financial Participation (FFP or federal matching dollars) for all waiver programs. Additional changes included in this action reflect formatting changes and do not have a substantive impact on these regulations.

Agency Contact: Victoria P. Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 786-7959.

12 VAC 30-60-300. Nursing facility criteria.

§ 1.0 Introduction.

A. Medicaid-funded long-term care services may be provided in either a nursing facility or community-based care setting. The criteria for assessing an individual's eligibility for Medicaid payment of nursing facility care consist of two components: 4- (i) functional capacity (the degree of assistance an individual requires to complete activities of daily living) and 2- (ii) medical or nursing needs. The criteria for assessing an individual's eligibility for Medicaid payment of community-based care consist of three components: 4- (i) functional capacity (the degree of assistance an individual requires to complete activities of daily living), 2- (ii) medical or nursing needs and 3- (iii) the individual's risk of nursing facility placement in the absence of community-based waiver services. In order to qualify for either Medicaid-funded

nursing facility care or Medicaid-funded community-based care, the individual must meet the same criteria.

~~1. In order to qualify for Medicaid payment for nursing facility care an individual must meet both functional capacity requirements and have a medical condition which requires ongoing medical or nursing management. An exception may be made when the individual does not meet the functional capacity requirement but the individual does have a health condition that requires the daily direct services of a licensed nurse that cannot be managed on an outpatient basis.~~

~~2. In order to qualify for Medicaid payment for Community-Based care an individual must either meet both the functional and medical components of the nursing facility criteria or meet the pre-nursing facility criteria defined in Section 2.2. In addition, the individual must be determined to be at risk of nursing facility placement unless services under the waiver are offered.~~

B. The preadmission screening process preauthorizes a continuum of long-term care services available to an individual under the Virginia Medical Assistance Program. Nursing Facilities' Preadmission Screenings to authorize Medicaid-funded long-term care are performed by teams composed by agencies contracting with the Department of Medical Assistance Services (DMAS). The authorization for Medicaid-funded long-term care ~~may~~ must be rescinded by the nursing facility or community-based care provider or by DMAS at any point that the individual is determined to no longer meet the criteria for Medicaid-funded long-term care. Medicaid-funded long-term care services are covered by the program for individuals whose needs meet the criteria established by program regulations. Authorization of appropriate non-institutional services shall be evaluated before nursing facility placement is considered.

C. Prior to an individual's admission, the nursing facility must review the completed pre-admission screening forms to ensure that appropriate nursing facility admission criteria have been documented. The nursing facility is also responsible for documenting, upon admission and on an ongoing basis, that the individual meets and continues to meet nursing facility criteria. For this purpose, the nursing facility will use the Minimum Data Set (MDS) The post admission assessment must be conducted no later than ~~fourteen~~ 14 days after the date of admission and promptly after a significant change in the resident's physical or mental condition. If at any time during the course of the resident's stay, it is determined that the resident does not meet nursing facility criteria as defined in the State Plan for Medical Assistance, the nursing facility must initiate discharge of such resident. Nursing facilities must conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity and medical and nursing needs.

The Department of Medical Assistance Services shall conduct surveys of the assessments completed by nursing facilities to determine that services provided to the residents meet nursing facility criteria and that needed services are provided.

D. The community-based provider is responsible for documenting upon admission and on an ongoing basis that

the individual meets the criteria for Medicaid-funded long-term care.

E. The criteria for nursing facility care under the Virginia Medical Assistance Program are contained herein. An individual's need for care must meet these criteria before any authorization for payment by Medicaid will be made for either institutional or non-institutional long-term care services. The Nursing Home Pre-Admission Screening team is responsible for documenting on the state-designated assessment instrument that the individual meets the criteria for nursing facility or community-based waiver services and for authorizing admission to Medicaid-funded long-term care. The rating of functional dependencies on the assessment instrument must be based on the individual's ability to function in a community environment, not including any institutionally induced dependence.

~~§ 1.1~~ 12 VAC 30-60-303. Preadmission screening criteria for nursing facility long-term care.

A. Functional dependency alone is not sufficient to demonstrate the need for nursing facility care or placement *or authorization for community-based care.*

~~B. Except as provided for in § 1.0-A,~~ An individual ~~may~~ shall only be considered to meet the nursing facility criteria when both the functional capacity of the individual and his medical or nursing needs meet the following requirements. Even when an individual meets nursing facility criteria, placement in a non-institutional setting shall be evaluated before actual nursing facility placement is considered.

1. Functional capacity.

a. When documented on a completed state-designated preadmission screening assessment instrument which is completed in a manner consistent with the definitions of activities of daily living and directions provided by DMAS for the rating of those activities, individuals may be considered to meet the functional capacity requirements for nursing facility care when one of the following describes their functional capacity:

(1) Rated dependent in two to four of the Activities of Daily Living, and also rated semi-dependent or dependent in Behavior Pattern and Orientation, and semi-dependent in Joint Motion or dependent in Medication Administration.

(2) Rated dependent in five to seven of the Activities of Daily Living, and also rated dependent in Mobility.

(3) Rated semi-dependent in two to seven of the Activities of Daily Living, and also rated dependent in Mobility and Behavior Pattern and Orientation.

b. The rating of functional dependencies on the pre-admission screening assessment instrument must be based on the individual's ability to function in a community environment, not including any institutionally induced dependence. The following abbreviations shall mean: I = independent; d = semi-dependent; D = dependent; MH = mechanical help; HH = human help.

(1) Bathing

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- (a) Without help (I)
 - (b) MH only (d)
 - (c) HH only (D)
 - (d) MH and HH (D)
 - (e) Performed by Others (D)
- (2) Dressing
- (a) Without help (I)
 - (b) MH only (d)
 - (c) HH only (D)
 - (d) MH and HH (D)
 - (e) Performed by Others (D)
 - (f) Is not Performed (D)
- (3) Toileting
- (a) Without help day or night(I)
 - (b) MH only (d)
 - (c) HH only (D)
 - (d) MH and HH (D)
 - (e) Performed by Others (D)
- (4) Transferring
- (a) Without help (I)
 - (b) MH only (d)
 - (c) HH only (D)
 - (d) MH and HH (D)
 - (e) Performed by Others (D)
 - (f) Is not Performed (D)
- (5) Bowel Function
- (a) Continent (I)
 - (b) Incontinent less than weekly (d)
 - (c) External/Indwelling Device/Ostomy - self care (d)
 - (d) Incontinent weekly or more (D)
 - (e) Ostomy - not self care (D)
- (6) Bladder Function
- (a) Continent (I)
 - (b) Incontinent less than weekly (d)
 - (c) External device/Indwelling Catheter/Ostomy - self care (d)
 - (d) Incontinent weekly or more (D)
 - (e) External device - not self care (D)
 - (f) Indwelling catheter - not self care (D)
 - (g) Ostomy - not self care (D)
- (7) Eating/Feeding
- (a) Without help (I)
 - (b) MH only (d)
 - (c) HH only (D)
 - (d) MH and HH (D)
 - (e) Spoon fed (D)
 - (f) Syringe or tube fed (D)
 - (g) Fed by IV or clysis (D)
- (8) Behavior Pattern and Orientation
- (a) Appropriate or Wandering/Passive less than weekly + Oriented (I)
 - (b) Appropriate or Wandering/Passive less than weekly + Disoriented - Some Spheres (I)
 - (c) Wandering/Passive Weekly/or more + Oriented (I)
 - (d) Appropriate or Wandering/Passive less than weekly + Disoriented - All Spheres (d)
 - (e) Wandering/Passive Weekly/Some or more + Disoriented - All Spheres (d)
 - (f) Abusive/Aggressive/Disruptive less than weekly + Oriented or Disoriented (d)
 - (g) Abusive/Aggressive Disruptive weekly or more + Oriented (d)
 - (h) Abusive/Aggressive Disruptive + Disoriented - All Spheres (D)
- (9) Mobility
- (a) Goes outside without help (I)
 - (b) Goes outside MH only (d)
 - (c) Goes outside HH only (D)
 - (d) Goes outside MH and HH (D)
 - (e) Confined - moves about (D)
 - (f) Confined - does not move about (D)
- (10) Medication Administration
- (a) No medications (I)
 - (b) Self administered - monitored less than weekly (I)
 - (c) By lay persons, Administered/Monitored (D)
 - (d) By Licensed /Professional nurse Administered/Monitored (D)
- (11) Joint Motion
- (a) Within normal limits (I)
 - (b) Limited motion (d)
 - (c) Instability - uncorrected or Immobile (I)
- a. c. An individual with medical or nursing needs is an individual whose health needs require medical or nursing

supervision or care above the level which could be provided through assistance with Activities of Daily Living, Medication Administration and general supervision and is not primarily for the care and treatment of mental diseases. Medical or nursing supervision or care beyond this level is required when any one of the following describes the individual's need for medical or nursing supervision:

(1) The individual's medical condition requires observation and assessment to assure evaluation of the person's need for modification of treatment or additional medical procedures to prevent destabilization and the person has demonstrated an inability to self observe ~~and/or~~ or evaluate the need to contact skilled medical professionals; ~~or~~

(2) Due to the complexity created by the person's multiple, interrelated medical conditions, the potential for the individual's medical instability is high or medical instability exists; or

(3) The individual requires at least one ongoing ~~medical/nursing~~ medical or nursing service. The following is a non-exclusive list of ~~medical/nursing~~ medical or nursing services which may, but need not necessarily, indicate a need for medical or nursing supervision or care:

- (a) Application of aseptic dressings;
- (b) Routine catheter care;
- (c) Respiratory therapy
- (d) Supervision for adequate nutrition and hydration for individuals who show clinical evidence of malnourishment or dehydration or have recent history of weight loss or inadequate hydration which, if not supervised would be expected to result in malnourishment or dehydration;
- (e) Therapeutic exercise and positioning;
- (f) Routine care of colostomy or ileostomy or management of neurogenic bowel and bladder;
- (g) Use of physical (e.g. side rails, poseys, locked wards) and/or chemical restraints;
- (h) Routine skin care to prevent pressure ulcers for individuals who are immobile;
- (i) Care of small uncomplicated pressure ulcers, and local skin rashes;
- (j) Management of those with sensory, metabolic, or circulatory impairment with denstrated clinical evidence of medical instability;
- (k) Chemotherapy;
- (l) Radiation;
- (m) Dialysis;
- (n) Suctioning;
- (o) Tracheostomy care;

(p) Infusion Therapy;

(q) Oxygen.

~~b. d.~~ Even when an individual meets nursing facility criteria, provision of services in a noninstitutional setting shall be considered before nursing facility placement is sought.

§ 1.2 12 VAC 30-60-307. Summary of pre-admission nursing facility criteria.

A. An individual shall be determined to meet the nursing facility criteria when:

1. The individual has both limited functional capacity and requires medical or nursing management according to the requirements of ~~Section 2.0~~ 12 VAC 30-60-303, or
2. The individual is rated dependent in some functional limitations, but does not meet the functional capacity requirements, and the individual requires the daily direct services or supervision of a licensed nurse that cannot be managed on an outpatient basis (e.g., clinic, physician visits, home health services).

B. An individual shall not be determined to meet nursing facility criteria when one of the following specific care needs solely describes his or her condition:

1. An individual who requires minimal assistance with activities of daily living, including those persons whose only need in all areas of functional capacity is for prompting to complete the activity;
2. An individual who independently uses mechanical devices such as a wheelchair, walker, crutch, or cane;
3. An individual who requires limited diets such as a mechanically altered, low salt, low residue, diabetic, reducing, and other restrictive diets;
4. An individual who requires medications that can be independently self-administered or administered by the caregiver;
5. An individual who requires protection to prevent him from obtaining alcohol or drugs or to address a ~~social/environmental~~ social or environmental problem;
6. An individual who requires minimal staff observation or assistance for confusion, memory impairment, or poor judgment;
7. An individual whose primary need is for behavioral management which can be provided in a community-based setting;

§ 1.3 12 VAC 30-60-312. Evaluation to determine eligibility for Medicaid payment of nursing facility or home and community-based care services.

A. The screening team shall not authorize Medicaid-funded nursing facility services for any individual who does not meet nursing facility criteria. Once the nursing home preadmission screening team has determined whether or not an individual meets the nursing facility criteria, the screening team must determine the most appropriate and cost-effective means of

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meeting the needs of the individual. The screening team must document a complete assessment of all the resources available for that individual in the community (i.e., the immediate family, other relatives, other community resources and other services in the continuum of long-term care which are less intensive than nursing facility level-of-care services). The screening team shall be responsible for preauthorizing Medicaid-funded long-term care according to the needs of each individual and the support required to meet those needs. The screening team shall authorize Medicaid-funded nursing facility care for an individual who meets the nursing facility criteria only when services in the community are either not a feasible alternative or the individual or the individual's representative rejects the screening team's plan for community services. The screening team must document that the option of community-based alternatives has been explained, the reason community-based services were not chosen, and have this document signed by the client or client's primary caregivers.

B. The screening team shall authorize community-based waiver services only for an individual who: ~~1. meets the nursing facility criteria and is at risk of nursing home placement without waiver services. Waiver services are offered to such an individual as an alternative to avoid nursing facility admission or pursuant to 42 CFR 441.302 (c)(1).~~

~~2. Meets the following Pre-Nursing Facility criteria and is at risk of nursing home placement without waiver services. Waiver services are offered to such an individual as a preventive service to delay or avoid nursing facility admission which would be required in the near future if community-based care is not offered. The Pre-Nursing Facility criteria are:~~

- ~~a. The individual is rated dependent in four of the activities of daily living and also rated dependent in mobility and has a need for medical or nursing supervision; or~~
- ~~b. The individual meets the functional dependency component of the nursing facility criteria but lacks a medical or nursing need.~~

C. Federal regulations which govern Medicaid-funded home and community-based services require that services only be offered to individuals who would otherwise require institutional placement in the absence of home- and community-based services. The determination that an individual would otherwise require placement in a nursing facility is based upon a finding that the individual's current condition and available support are insufficient to enable the individual to remain in the home and thus the individual is at risk of institutionalization if community-based care is not authorized. The determination of the individual's risk of nursing facility placement shall be documented either on the state-designated pre-admission screening assessment or in a separate attachment for every individual authorized to receive community-based waiver services. To authorize community-based waiver services, the screening team must document that the individual is at risk of nursing facility placement by finding that one of the following conditions is met:

1. Application for the individual to a nursing facility has been made and accepted;

2. The individual has been cared for in the home prior to the assessment and evidence is available demonstrating a deterioration in the individual's health care condition or a change in available support preventing former care arrangements from meeting the individual's need. Examples of such evidence may be, but shall not necessarily be limited to:

- a. Recent hospitalizations,
- b. Attending physician documentation, or
- c. Reported findings from medical or social service agencies.

3. There has been no change in condition or available support but evidence is available that demonstrates the individual's functional, medical and nursing needs are not being met. Examples of such evidence may be, but shall not necessarily be limited to:

- a. Recent hospitalizations,
- b. Attending physician documentation, or
- c. Reported findings from medical or social service agencies.

§ 1.4. 12 VAC 30-60-316. Criteria for continued nursing facility care using the Minimum Data Set (MDS).

Individuals may be considered appropriate for nursing facility care when one of the following describes their medical or nursing needs and functional capacity as recorded on the Minimum Data Set (MDS) of the Resident Assessment Instrument that is specified by the Commonwealth.

A. 1. Functional capacity:

- ~~1. a. The individual meets criteria for two to four of the Activities of Daily Living, plus Behavior and Orientation, and Joint Motion; or~~
- ~~2. b. The individual meets criteria for five to seven of the Activities of Daily Living and also for Locomotion, or~~
- ~~3. c. The individual meets criteria for two to seven of the Activities of Daily Living and also for Locomotion, and Behavior and Orientation. An individual in this category will not be appropriate for nursing facility care unless he also has a medical condition requiring treatment or observation by a nurse.~~

~~B. 2. Medical or Nursing Needs: The individual has health needs which require medical or nursing supervision or care above the level which could be provided through assistance with activities of daily living, medication administration and general supervision and is not primarily for the care and treatment of mental diseases.~~

§ 1.5. 12 VAC 30-60-318. Definitions to be applied when completing the MDS.

A. Activities of Daily Living (ADLs):

1. Transfer (§ E(1)(b)). In order to meet this ADL, the individual must score a 1, 2, 3, 4, or 8 as described below:

- a. (0) Independent - No help or oversight - OR - help/oversight provided only 1 or 2 times during last 7 seven days
- b. (1) Supervision - Oversight, encouragement or cueing provided 3+ times during last 7 seven days - OR - supervision plus physical assistance provided on 1 or 2 times during last 7 seven days
- c. (2) Limited assistance - Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3+ times - OR - more help provided only 1 or 2 times during last 7 seven days
- d. (3) Extensive assistance - While resident performed part of activity, over last 7 seven-day period, help of following type or types was provided 3 or more times: weight-bearing support or full staff performance during part (but not all) of last 7 seven days
- e. (4) Total dependence - Full staff performance of activity during entire 7 seven days
- f. (8) Activity did not occur during the entire 7 seven-day period. Use of this code is limited to situations where the ADL activity was not performed and is primarily applicable to fully bed-bound residents who neither transferred from bed nor moved between locations over the entire 7 seven-day period.

2. Dressing (§ E(1)(d)). In order to meet this ADL, the individual must score a 1, 2, 3, 4, or 8 as described below:

- a. (0) Independent - No help or oversight - OR - help/oversight provided only 1 or 2 times during last 7 seven days
- b. (1) Supervision - Oversight, encouragement or cueing provided 3+ times during last 7 seven days - OR - supervision plus physical assistance provided on 1 or 2 times during last 7 seven days
- c. (2) Limited assistance - Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3+ times - OR - more help provided only 1 or 2 times during last 7 seven days
- d. (3) Extensive assistance - While resident performed part of activity, over last 7 seven-day period, help of following type or types was provided 3 or more times: weight-bearing support or full staff performance during part (but not all) of last 7 seven days
- e. (4) Total dependence - Full staff performance of activity during entire 7 seven days
- f. (8) Activity did not occur during the entire 7 seven-day period. Use of this code is limited to situations where the ADL activity was not performed and is primarily applicable to fully bed-bound residents who neither transferred from bed nor moved between locations over the entire 7 seven-day period.

3. Eating (§ E(1)(e)). In order to meet this ADL, the individual must score a 1, 2, 3, 4, or 8 as described below:

- a. (0) Independent - No help or oversight - OR - help/oversight provided only 1 or 2 times during last 7 seven days
- b. (1) Supervision - Oversight, encouragement or cueing provided 3+ times during last 7 seven days - OR - supervision plus physical assistance provided on 1 or 2 times during last 7 seven days
- c. (2) Limited assistance - Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3+ times - OR - more help provided only 1 or 2 times during last 7 seven days
- d. (3) Extensive assistance - While resident performed part of activity, over last 7 seven-day period, help of following type or types was provided 3 or more times: weight-bearing support or full staff performance during part (but not all) of last 7 seven days
- e. (4) Total dependence - Full staff performance of activity during entire 7 seven days
- f. (8) Activity did not occur during the entire 7 seven-day period. Use of this code is limited to situations where the ADL activity was not performed and is primarily applicable to fully bed-bound residents who neither transferred from bed nor moved between locations over the entire 7 seven-day period, or

g. To meet this ADL, one of the following is checked:

- (1) § L(4)(a) Parenteral or intravenous
- (2) § L(4)(b) Feeding tube
- (3) § L(4)(d) Syringe (oral feeding)

4. Toilet Use § E(1)(f)). In order to meet this ADL, the individual must score a 1, 2, 3, 4, or 8 as described below:

- a. (0) Independent - No help or oversight - OR - help/oversight provided only 1 or 2 times during last 7 seven days
- b. (1) Supervision - Oversight, encouragement or cueing provided 3+ times during last 7 days - OR -supervision plus physical assistance provided on 1 or 2 times during last 7 days
- c. (2) Limited assistance - Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3+ times - OR - more help provided only 1 or 2 times during last 7 seven days
- d. (3) Extensive assistance - While resident performed part of activity, over last 7 seven-day period, help of following type or types was provided 3 or more times: weight-bearing support or full staff performance during part (but not all) of last 7 seven days
- e. (4) Total dependence - Full staff performance of activity during entire 7 seven days

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f. (8) Activity did not occur during the entire 7 seven-day period. Use of this code is limited to situations where the ADL activity was not performed and is primarily applicable to fully bed-bound residents who neither transferred from bed nor moved between locations over the entire 7 seven-day period.

5. Bathing (§ E(3)(a)). To meet this ADL, the individual must score a 1, 2, 3, 4, or 8 as described below:

- a. (0) Independent - no help provided.
- b. (1) Supervision - oversight help only
- c. (2) Physical help limited to transfer only
- d. (3) Physical help in part of bathing activity
- e. (4) Total dependence

f. (8) Activity did not occur during the entire 7 seven-day period. Use of this code is limited to situations where the ADL activity was not performed and is primarily applicable to fully bed-bound residents who neither transferred from bed nor moved between locations over the entire 7 seven-day period.

6. Bladder Continence (§ F(1)(b)). In order to meet this ADL, the individual must score a 2, 3, or 4 in this category:

- a. (0) Continent - Complete control
- b. (1) Usually continent - incontinent episodes once a week or less
- c. (2) Occasionally incontinent - 2+ times a week but not daily
- d. (3) Frequently incontinent - tended to be incontinent daily, but some control present (e.g., on day shift)
- e. (4) Incontinent - Had inadequate control; multiple daily episodes or

f. To meet this ADL, one of the following is checked:

- (1) § F(3)(b) external cathether
- (2) § F(3)(c) indwelling catheter

7. Bowel Continence (§ F(1)(a)). In order to meet this ADL, the individual must score a 2, 3, or 4 in this category:

- a. (0) Continent - Complete control
- b. (1) Usually continent - control problems less than weekly
- c. (2) Occasionally incontinent - once a week
- d. (3) Frequently incontinent - 2-3 times a week
- e. (4) Incontinent - Had inadequate control all (or almost all) of the time, or
- f. To meet this ADL, § F(3)(h) ostomy is checked.

B. Joint Motion (§ E(4)). In order to meet this category, at least one of the following must be checked:

- 1. § E(4)(c) Contracture to arms, legs, shoulders, or hands
- 2. (d) Hemiplegia/hemiparesis

3. (e) Quadriplegia

4. (f) Arm - partial or total loss of voluntary movement

5. (g) Hand - lack of dexterity (e.g., problem using toothbrush or adjusting hearing aid)

6. (h) Leg - partial or total loss of voluntary movement

7. (i) Leg - unsteady gait

8. (j) Trunk - partial or total loss of ability to position, balance, or turn body

C. Locomotion (§ E(1)(c)). In order to meet this ADL, the individual must score a 1, 2, 3, 4, or 8 in this category:

1. (0) Independent - No help or oversight - OR - help/oversight provided only 1 or 2 times during last 7 seven days

2. (1) Supervision - Oversight, encouragement or cueing provided 3+ times during last 7 seven days - OR - supervision plus physical assistance provided on 1 or 2 times during last 7 seven days

3. (2) Limited assistance - Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3+ times - OR - more help provided only 1 or 2 times during last 7 seven days

4. (3) Extensive assistance - While resident performed part of activity, over last 7 seven day period, help of following type or types was provided 3 or more times: weight-bearing support or full staff performance during part (but not all) of last 7 seven days

5. (4) Total dependence - Full staff performance of activity during entire 7 seven days

6. (8) Activity did not occur during the entire 7 seven-day period. Use of this code is limited to situations where the ADL activity was not performed and is primarily applicable to fully bed-bound residents who neither transferred from bed nor moved between locations over the entire 7 seven-day period.

D. Nursing Observation. In order to meet this category, at least one of the following special treatments, procedures and skin conditions must be checked:

1. § N(4)(a) Open lesions other than stasis or pressure ulcers (e.g., cuts)

(f) Wound care or treatment (e.g., pressure ulcer care, surgical wound)

(g) Other skin care or treatment

2. § P(1)(a) Chemotherapy

(b) Radiation

(c) Dialysis

(d) Suctioning

(e) Tracheostomy care

(f) Intravenous medications

- (g) Transfusions
- (h) Oxygen
- (i) Other special treatment or procedure

E. Behavior and Orientation. In order to meet this category, the individual must meet at least one of the categories for both behavior AND orientation.

1. Behavior. To meet the criteria for behavior, the individual must meet at least one of the following:

- a. § H(1)(d) Failure to eat or take medications, withdrawal from self-care or leisure activities (must be checked), or
- b. One of the following is coded 1 (behavior of this type occurred less than daily) or 2 (behavior of this type occurred daily or more frequently):
 - (1) § H(3)(a) Wandering (moved with no rational purpose, seemingly oblivious to needs or safety)
 - (2) § H(3)(b) Verbally abusive (others were threatened, screamed at, cursed at)
 - (3) § H(3)(c) Physically abusive (others were hit, shoved, scratched, sexually abused)
 - (4) § H(3)(d) Socially inappropriate/disruptive behavior (made disrupting sounds, noisy, screams, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings)

2. Orientation: To meet this category, the individual must meet at least one of the following:

- a. § B(3)(d) Awareness that individual is in a nursing home - is not checked;
- b. § B(3)(e) None of the memory/recall ability items are recalled -must be checked; or
- c. § B(4) Cognitive skills for daily decision-making - must be coded with a 2 (moderately impaired - decisions poor; cues/supervision required) or 3 (severely impaired - never/rarely made decisions).

VA.R. Doc. No. R02-160; Filed April 22, 2002, 11:27 a.m.

Title of Regulation: Nursing Home Payment System Resource Utilization Groups (RUGs).

12 VAC 30-90. Methods and Standards for Establishing Payment Rates for Long-Term Care (amending [12 VAC 30-90-10, 12 VAC 30-90-20, 12 VAC 30-90-38,] 12 VAC 30-90-40, 12 VAC 30-90-41, 12 VAC 30-90-60, 12 VAC 30-90-271, 12 VAC 30-90-272 [, and 12 VAC 30-90-280]; adding 12 VAC 30-90-305, 12 VAC 30-90-306, and 12 VAC 30-90-307; repealing 12 VAC 30-90-300, 12 VAC 30-90-301, 12 VAC 30-90-302, 12 VAC 30-90-303, and 12 VAC 30-90-304).

Statutory Authority: § 32.1-325 of the Code of Virginia.

Effective Date: July 1, 2002.

Summary:

The amendments replace the current Patient Intensity Rating System (PIRS) method of classifying nursing facility residents with the Resource Utilization Groups-III (RUGs) methodology, as directed by the 2000 General Assembly (Chapter 1073 of the 2000 Acts of Assembly, Item 319 MM). The proposed amendments also reclassify nursing staff costs for quality assurance services as direct patient care costs rather than indirect costs and establish a new method for calculating inflation in the nursing home payment system.

Summary of Public Comments and Agency's Response: A summary of comments made by the public and the agency's response may be obtained from the promulgating agency or viewed at the office of the Registrar of Regulations.

Agency Contact: N. Stanley Fields, Director, Division of Reimbursement and Cost Settlement, Department of Medical Assistance Services, 600 E. Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 786-5590, FAX (804) 786-0729 or e-mail sfields@dmass.state.va.us.

REGISTRAR'S NOTICE: The proposed regulation was adopted as published in 18:11 VA.R. 1380-1396 February 11, 2002, with the additional changes shown below. Therefore, pursuant to § 2.2-4031 A of the Code of Virginia, the text of the final regulation is not set out at length; however, the changes from the proposed regulation are printed below.

[12 VAC 30-90-10. Methods and standards for establishing payment rates for long-term care.

The policy and the method to be used in establishing payment rates for nursing facilities listed in § 1905(a) of the Social Security Act and included in this State Plan for Medical Assistance are described in the following paragraphs.

1. Reimbursement and payment criteria will be established which are designed to enlist participation of a sufficient number of providers of services in the Program so that eligible persons can receive the medical care and services included in the Plan to the extent these are available to the general population.

2. Participation in the Program will be limited to providers of services who accept, as payment in full, the amounts so paid.

3. Payment for care of service will not exceed the amounts indicated to be reimbursed in accord with the policy and the methods described in the Plan and payments will not be made in excess of the upper limits described in 42 CFR 447.253(b)(2). The state agency has continuing access to data identifying the maximum charges allowed. Such data will be made available to the Secretary of Health and Human Services upon request.

4. Payments for services to nursing facilities shall be on the basis of reasonable cost in accordance with the standards and principles set forth in 42 CFR 447.252 as follows:

- a. A uniform annual cost report which itemizes allowable cost will be required to be filed within 150 days of each provider's fiscal year end.

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b. The determination of allowable costs will be in accordance with Medicare principles as established in the Provider Reimbursement Manual (PRM-15) except where otherwise noted in this Plan.

c. Field audits will be conducted on the cost data submitted by the provider to verify the accuracy and reasonableness of such data. Audits will be conducted for each facility on a periodic basis as determined from internal desk audits and more often as required. Audit procedures are in conformance with SSA standards set forth in PRM-13-2. Internal desk audits are conducted annually within six months of receipt of a completed cost report from the provider.

d. Reports of field audits are retained by the state agency for at least three years following submission of the report.

e. Facilities are paid on a cost-related basis in accordance with the methodology described in the Plan.

f. Modifications to the Plan for reimbursement will be submitted as Plan amendments.

g. Covered cost will include such items as:

(1) Cost of meeting certification standards.

(2) Routine services, which include items expense providers normally incur in the provision of services.

(3) The cost of such services provided by related organizations except as modified in the payment system at Part II (12 VAC 30-90-20 et seq.) of this chapter.

h. Bad debts, charity and courtesy allowances shall be excluded from allowable cost.

i. Effective for facility cost reporting periods beginning on or after October 1, 1978, the reimbursable amount will be determined prospectively on a facility by facility basis, except that mental institutions and mental retardation facilities shall continue to be reimbursed retrospectively *and effective July 1, 2002, the Virginia Veterans Care Center nursing facility shall be reimbursed retrospectively.* The prospective rate will be based on the prior period's actual cost (as determined by an annual cost report and verified by audit as set forth in subdivision 4 c of this section) plus an inflation factor. Payments will be made to facilities no less than monthly.

j. The payment level calculated by the prospective rate will be adequate to reimburse in full such actual allowable costs that an economically and efficiently operated facility must incur. In addition, an incentive plan will be established as described in the payment system at 12 VAC 30-90-20 et seq.

k. Upper limits for payment within the prospective payment system shall be as follow:

(1) Allowable cost shall be determined in accordance with Medicare principles as defined in PRM-15, except as may be modified in this plan.

(2) Reimbursement for operating costs will be limited to regional ceilings.

(3) Reimbursement, in no instance, will exceed the charges for private patients receiving the same services. In accordance with § 1903(a)(2)(B) of the Social Security Act, nursing facility costs incurred in relation to training and competency evaluation of nurse aides will be considered as State administrative expenses and, as such, shall be exempted from this provision.

l. In accordance with 42 CFR 447.205, an opportunity for public comment was permitted before final implementation of rate setting processes.

m. A detailed description of the prospective reimbursement formula is attached for supporting detail.

n. Item 398D of the 1987 Appropriation Act (as amended), effective April 8, 1987, eliminated reimbursement of return on equity capital to proprietary providers.

5. Reimbursement of nonenrolled long term care facilities.

a. Nonenrolled providers of institutional long term care services shall be reimbursed based upon the average per diem cost, updated annually, reimbursed to enrolled nursing facility providers.

b. Prior approval must be received from the DMAS for recipients to receive institutional services from nonenrolled long-term care facilities. Prior approval can only be granted:

(1) When the nonenrolled long-term care facility with an available bed is closer to the recipient's Virginia residence than the closest facility located in Virginia with an available bed;

(2) When long-term care special services, such as intensive rehabilitation services, are not available in Virginia; or

(3) If there are no available beds in Virginia facilities.

6. Specialized care services. The payment methodology for specialized care services is contained in Part XVII (12 VAC 30-90-350 et seq.) of the Nursing Home Payment System.]

[**12 VAC 30-90-20. Nursing home payment system; generally.**

A. Effective July 1, 2001, the payment methodology for nursing facility (NF) reimbursement by the Virginia Department of Medical Assistance Services (DMAS) is set forth in this part.

B. Three separate cost components are used: plant or capital, as appropriate, cost; operating cost; and nurse aide training and competency evaluation program and competency evaluation program (NATCEPs) costs. The rates, which are determined on a facility-by-facility basis, shall be based on annual cost reports filed by each provider.

C. Effective July 1, 2001, in determining the ceiling limitations, there shall be direct patient care medians established for nursing facilities in the Virginia portion of the Washington DC-MD-VA Metropolitan Statistical Area (MSA), the Richmond-Petersburg Metropolitan Statistical Area (MSA), and in the rest of the state. There shall be indirect patient care medians

established for nursing facilities in the Virginia portion of the Washington DC-MD-VA MSA, for NFs with less than 61 beds in the rest of the state, and for NFs with more than 60 beds in the rest of the state. The Washington DC-MD-VA MSA and the Richmond-Petersburg MSA shall include those cities and counties as listed and changed from time to time by the Health Care Financing Administration (HCFA). A nursing facility located in a jurisdiction which HCFA adds to or removes from the Washington DC-MD-VA MSA or the Richmond-Petersburg MSA shall be placed in its new peer group, for purposes of reimbursement, at the beginning of its next fiscal year following the effective date of HCFA's final rule.

D. Institutions for mental diseases providing nursing services for individuals age 65 and older shall be exempt from the prospective payment system as defined in Articles 1 (12 VAC 30-90-29), 3 (12 VAC 39-90-35 et seq.), 4 (12 VAC 39-90-40 et seq.), 6 (12 VAC 30-90-60 et seq.), and 8 (12 VAC 30-90-80 et seq.) of this subpart, as are mental retardation facilities and effective July 1, 2002, as is the Virginia Veterans Care Center nursing facility. All other sections of this payment system relating to reimbursable cost limitations shall apply. These facilities shall continue to be reimbursed retrospectively on the basis of reasonable costs in accordance with Medicare principles of reimbursement and Medicaid principles of reimbursement in effect on June 30, 2000, except that those that are defined as skilled nursing facilities (SNFs) and are operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services shall not be subject to the routine cost limits that are normally required and applicable under Medicare principles of reimbursement. Reimbursement to Intermediate Care Facilities for the Mentally Retarded (ICF/MR) shall be limited to the highest rate paid to a state ICF/MR institution, approved each July 1 by DMAS.

E. Except as specifically modified herein, Medicare principles of reimbursement, as amended from time to time, shall be used to establish the allowable costs in the rate calculations. Allowable costs must be classified in accordance with the DMAS uniform chart of accounts (see 12 VAC 30-90-270 through 12 VAC 30-90-276) and must be identifiable and verifiable by contemporaneous documentation.

All matters of reimbursement which are part of the DMAS reimbursement system shall supersede Medicare principles of reimbursement. Wherever the DMAS reimbursement system conflicts with Medicare principles of reimbursement, the DMAS reimbursement system shall take precedence. Appendices are a part of the DMAS reimbursement system.]

[12 VAC 30-90-38. Schedule of assets reporting.

A. For the calculation of facility average age, the department shall use a "schedule of assets" that lists, by year of acquisition, the allowable acquisition cost of facilities' assets, including land improvements, buildings and fixed equipment, and major movable equipment. This schedule shall be submitted annually by the provider on forms to be provided by the department, and shall be audited by the department. The principles of reimbursement for plant cost described in Article 2 (12 VAC 30-90-30 et seq.) of this subpart shall be used to determine allowable cost.

B. The schedule of assets used in the calculation of average age shall be submitted with the provider's cost report.

C. Facilities failing to submit the schedule of assets timely shall have their nursing facility per diem rate set to zero.

D. Capital expenditures are to be included on the schedule of assets. These do not include land purchases, but do include land improvements, renovations, additions, upgrading to new standards, and equipment purchases. Capital expenditures shall be capital related expenditures costing \$50,000 or more each, in aggregate for like items, or in aggregate for a particular project. ~~These include purchases of similar type equipment or like items within a 12-month period.~~ For facilities with 30 or fewer beds, an amount of \$25,000, rather than \$50,000, shall apply. The limits of \$50,000 and \$25,000 shall apply only to expenditures after July 1, 2000. *For these purposes, like items means those items acquired within a 12-month period that are classified in one of the categories of land improvements, building improvements, or movable equipment. Additionally, capital-related expenditures that are part of a particular project may be included on the schedule of assets for the cost reporting that is after the date the assets have been placed into service, whether all the required \$50,000 threshold of costs of the ongoing project have been incurred as of the reporting date.*

E. Items reportable on the schedule of assets may be removed only when disposed of.

F. Acquisition costs related to any sale or change in the ownership of a nursing facility or the assets of a nursing facility shall not be included in the schedule of assets if the transaction occurred after June 30, 2000. Whether such a transaction is the result of a sale of assets, acquisition of capital stock, merger, or any other type of change in ownership, related costs shall not be reported on the schedule of assets.

G. In addition to verifying the schedule of assets, audits of NF allowable capital costs shall continue to be performed in accordance with regulations described in Article 2.]

12 VAC 30-90-40. [No change from proposed.]

12 VAC 30-90-41. Nursing facility reimbursement formula.

A. Effective on and after ~~October 1, 1990~~ July 1, 2002, all NFs subject to the prospective payment system shall be reimbursed under a revised formula entitled "The Patient Intensity Rating System (PIRS)." ~~PIRS is a patient-based methodology which links NFs Resource Utilization Group-III (RUG-III) System [as defined in Appendix IV (12 VAC 30-90-305 through 12 VAC 30-90-307)]." RUG-III is a resident classification system that groups NF residents according to resource utilization. Case-mix indices (CMIs) are assigned to RUG-III groups and are used to adjust the NF's per diem rates to reflect the intensity of services required by a NF's patient NF's resident mix. Three classes were developed which group patients together based on similar functional characteristics and service needs. See [12 VAC 30-90-300 12 VAC 30-90-305 through 12 VAC 30-90-307] for details on the Resource Utilization Groups.~~

1. Any NF receiving Medicaid payments on or after October 1, 1990, shall satisfy all the requirements of § 1919(b)

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through (d) of the Social Security Act as they relate to provision of services, residents' rights and administration and other matters.

2. Direct and indirect group ceilings and rates.

a. In accordance with 12 VAC 30-90-20 C, direct patient care operating cost peer groups shall be established for the Virginia portion of the Washington DC-MD-VA MSA, the Richmond-Petersburg MSA and the rest of the state. Direct patient care operating costs shall be as defined in 12 VAC 30-90-271.

b. ~~Effective July 1, 2001,~~ Indirect patient care operating cost peer groups shall be established for the Virginia portion of the Washington DC-MD-VA MSA, for the rest of the state for facilities with less than 61 licensed beds, and for the rest of the state for facilities with more than 60 licensed beds.

~~3. Each NFs Service Intensity Index (SII) shall be calculated for each semiannual period of a NFs fiscal year based upon data reported by that NF and entered into DMAS' Long Term Care Information System (LTCIS). Data will be reported on the multidimensional assessment form prescribed by DMAS (now DMAS-80) at the time of admission and then twice a year for every Medicaid recipient in a NF. The NFs SII, derived from the assessment data, will be normalized by dividing it by the average for all NFs in the state.~~

~~See 2 VAC 30-90-300 for the PIRS class structure, the relative resource cost assigned to each class, the method of computing each NFs facility score and the methodology of computing the NFs semiannual SII.~~ 3. Each facility's average case-mix index shall be calculated based upon data reported by that nursing facility to the Centers for Medicare and Medicaid Services (CMS) (formerly HCFA) Minimum Data Set (MDS) System. See 12 VAC 30-90-306 for the case-mix index calculations.

4. The normalized ~~SII~~ facility average Medicaid CMI shall be used to calculate the direct patient care operating cost prospective ceilings and direct patient care operating cost prospective rates for each semiannual period of a NFs subsequent fiscal years year. See 12 VAC 30-90-306 D 2 for the calculation of the normalized facility average Medicaid CMI.

a. A NFs direct patient care operating cost prospective ceiling shall be the product of the NFs peer group direct patient care ceiling and the NFs normalized ~~SII~~ for the previous semiannual period facility average Medicaid CMI. A NFs direct patient care operating cost prospective ceiling will be calculated semiannually.

b. An ~~SII~~ rate adjustment, if any, shall be applied to a NFs prospective direct patient care operating cost base rate for each semiannual period of a NFs fiscal year. The ~~SII~~ determined in the second semiannual period of the previous fiscal year shall be divided by the average of the previous fiscal year's SIIs to determine the ~~SII~~ rate adjustment, if any, to the first semiannual period of the subsequent fiscal year's prospective direct patient care operating cost base rate. The ~~SII~~ determined in the first

~~semiannual period of the subsequent fiscal year shall be divided by the average of the previous fiscal year's SIIs to determine the ~~SII~~ rate adjustment, if any, to the second semiannual period of the subsequent fiscal year's prospective direct patient care operating cost base rate. A CMI rate adjustment for each semiannual period of a nursing facility's prospective fiscal year shall be applied by multiplying the nursing facility's normalized facility average Medicaid CMI applicable to each prospective semiannual period by the nursing facility's case-mix neutralized direct patient care operating cost base rate for the preceding cost reporting period (see 12 VAC 30-90-307).~~

~~c. See 12 VAC 30-90-300 for an illustration of how the ~~SII~~ is used to adjust direct patient care operating ceilings and the semiannual rate adjustments to the prospective direct patient care operating cost base rate 12 VAC 30-90-307 for the applicability of case-mix indices.~~

5. Effective for services on and after July 1, 2001 2002, the following changes shall be made to the direct and indirect payment methods.

a. The direct patient care operating ceiling shall be set at 112% of the ~~respective peer group day-weighted~~ median of facility specific direct cost the facilities' case-mix neutralized direct care operating costs per day. The calculation of the median medians shall be based on cost reports from freestanding nursing homes for provider fiscal years ending in calendar the most recent base year 1998. The median medians used to set the peer group direct ceiling patient care operating ceilings shall be revised and case-mix neutralized every two years using [more the most] recent [reliable calendar year] cost [data settled cost reports for freestanding nursing facilities that have been completed as of September 1]. In addition, for ceilings effective during July 1, 2000, through June 30, 2002, the ceiling calculated as described herein shall be increased by two per diem amounts. The first per diem amount shall equal \$21,716,649, increased for inflation from SFY 2000 to SFY 2001, divided by Medicaid days in SFY 2000. The second per diem amount shall equal \$1,400,000 divided by Medicaid days in SFY 2000. When this ceiling calculation is completed for services after June 30, 2002, the per diem amount related to the amount of \$21,716,649 shall not be added.

b. Facility specific direct cost per day amounts used to calculate direct reimbursement rates for dates of service on and after July 1, 2000, shall be increased by the two per diem amounts described in subdivision 5 a of this subsection. However, the per diem related to the amount of \$21,716,649 shall be included only in proportion to the number of calendar days in the provider fiscal year the data are taken from that do not fall after July 1, 1999. That is, for a cost report from a provider fiscal year ending December 31, 1999, the specified increase would apply to about half of the year.

e. b. The indirect patient care operating ceiling shall be set at 106.9% of the ~~respective peer group day-weighted~~ median of facility the facility's specific indirect operating

cost per day. The calculation of the ~~median~~ peer group medians shall be based on cost reports from freestanding nursing homes for provider fiscal years ending in ~~calendar~~ the most recent base year ~~1998~~. The medians used to set the peer group indirect operating ceilings shall be revised every two years using ~~[more the most]~~ recent ~~[reliable~~ calendar year] cost ~~[data—settled cost reports for freestanding nursing facilities that have been completed as of September 1]~~.

~~B. The allowance for inflation shall be based on the percentage of change in the moving average of the Skilled Nursing Facility Market Basket of Routine Service Costs, as developed by Data Resources, Incorporated, adjusted for Virginia, determined in the quarter in which the NFs most recent fiscal year ended. NFs shall have their prospective operating cost ceilings and prospective operating cost rates established in accordance with the following methodology:~~

~~1. The initial peer group ceilings established under this section shall be the final peer group ceilings for a NF's first full or partial cost reporting fiscal year under PIRS. Peer group ceilings for subsequent fiscal years shall be calculated by use of the adjusted medians determined at June 30, 2000, for direct and indirect cost. These adjusted medians shall be considered the final interim ceilings for subsequent fiscal years. The final interim ceilings determined above shall be adjusted by adding 100% of historical inflation from June 30, 2000, to the beginning of the NFs next fiscal year to obtain the new "interim" ceilings, and 50% of the forecasted inflation to the end of the NFs next fiscal year.~~

~~2. A NFs average allowable operating cost rates, as determined from its most recent fiscal year's cost report, shall be adjusted by 50% of historical inflation and 50% of the forecasted inflation to calculate its prospective operating cost base rates.~~

B. Adjustment of ceilings and costs for inflation. Effective for provider fiscal years starting on and after July 1, 2002, ceilings and rates shall be adjusted for inflation each year using the moving average of the percentage change of the Virginia-Specific Nursing Home Input Price Index, updated quarterly, published by Standard & Poor's DRI.

1. For provider years beginning in each calendar year, the percentage used shall be the moving average for the second quarter of the year, taken from the table published for the fourth quarter of the previous year. For example, in setting prospective rates for all provider years beginning in January through December 2002, ceilings and costs would be inflated using the moving average for the second quarter of 2002, taken from the table published for the fourth quarter of 2001.

2. Provider specific costs shall be adjusted for inflation each year from the cost reporting period to the prospective rate period using the moving average as specified in subdivision 1 of this subsection. If the cost reporting period or the prospective rate period is less than 12 months long, a fraction of the moving average shall be used that is equal to the fraction of a year from the midpoint of the cost reporting period to the midpoint of the prospective rate period.

3. Ceilings shall be adjusted from the common point established in the most recent rebasing calculation. Base period costs shall be adjusted to this common point using moving averages from the DRI tables corresponding to the provider fiscal period, as specified in subdivision 1 of this subsection. Ceilings shall then be adjusted from the common point to the prospective rate period using the moving average(s) for each applicable second quarter, taken from the DRI table published for the fourth quarter of the year immediately preceding the calendar year in which the prospective rate years begin. Rebased ceilings shall be effective on July 1 of each rebasing year, so in their first application they shall be adjusted to the midpoint of the provider fiscal year then in progress or then beginning. Subsequently, they shall be adjusted each year from the common point established in rebasing to the midpoint of the appropriate provider fiscal year. For example, suppose the base year is made up of cost reports from years ending in calendar year 2000, the rebasing year is SFY2003, and the rebasing calculation establishes ceilings that are inflated to the common point of July 1, 2002. Providers with years in progress on July 1, 2002, would receive a ceiling effective July 1, 2002, that would be adjusted to the midpoint of the provider year then in progress. In some cases this would mean the ceiling would be reduced from the July 1, 2002, ceiling level. The following table shows the application of these provisions for different provider fiscal periods.

Table I
Application of Inflation to Different Provider Fiscal Periods

| Provider FYE | Effective Date of New Ceiling | First PFYE After Rebasing Date | Inflation Time Span from Ceiling Date to Midpoint of First PFY | Second PFYE After Rebasing Date | Inflation Time Span from Ceiling Date to Midpoint of Second PFY |
|--------------|-------------------------------|--------------------------------|--|---------------------------------|---|
| 3/31 | 7/1/02 | 3/31/03 | + 1/4 year | 3/31/04 | + 1-1/4 years |
| 6/30 | 7/1/02 | 6/30/03 | + 1/2 year | 6/30/04 | + 1-1/2 years |
| 9/30 | 7/1/02 | 9/30/02 | - 1/4 year | 9/30/03 | + 3/4 year |
| 12/31 | 7/1/02 | 12/31/02 | -0- | 12/31/03 | + 1 year |

The following table shows the DRI tables that would provide the moving averages for adjusting ceilings for different prospective rate years.

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Table II
Source Tables for DRI Moving Average Values

| Provider FYE | Effective Date of New Ceiling | First PFYE After Rebasing Date | Source DRI Table for First PFY Ceiling Inflation | Second PFYE After Rebasing Date | Source DRI Table for Second PFY Ceiling Inflation |
|--------------|-------------------------------|--------------------------------|--|---------------------------------|---|
| 3/31 | 7/1/02 | 3/31/03 | Fourth Quarter 2001 | 3/31/04 | Fourth Quarter 2002 |
| 6/30 | 7/1/02 | 6/30/03 | Fourth Quarter 2001 | 6/30/04 | Fourth Quarter 2002 |
| 9/30 | 7/1/02 | 9/30/02 | Fourth Quarter 2000 | 9/30/03 | Fourth Quarter 2001 |
| 12/31 | 7/1/02 | 12/31/02 | Fourth Quarter 2000 | 12/31/03 | Fourth Quarter 2001 |

In this example, when ceilings are inflated for the second PFY after the rebasing date, the ceilings will be inflated from July 1, 2002, using moving averages from the DRI table specified for the second PFY. That is, the ceiling for years ending June 30, 2004, will be the June 30, 2002, base period ceiling, adjusted by 1/2 of the moving average for the second quarter of 2002, compounded with the moving average for the second quarter of 2003. Both these moving averages will be taken from the fourth quarter 2002 DRI table.

C. The ~~PIRS RUG-III [method~~ Nursing Home Payment System] shall still require comparison of the prospective operating cost rates to the prospective operating ceilings. The provider shall be reimbursed the lower of the prospective operating cost ~~rates rate~~ or prospective operating ~~ceilings ceiling~~.

D. Nonoperating costs. Plant or capital, as appropriate, costs shall be reimbursed in accordance with Articles 1, 2, and 3 of this subpart. Plant costs shall not include the component of cost related to making or producing a supply or service.

NATCEPs cost shall be reimbursed in accordance with 12 VAC 30-90-170.

E. The prospective rate for each NF shall be based upon operating cost and plant/capital cost components or charges, whichever is lower, plus NATCEPs costs. The disallowance of nonreimbursable operating costs in any current fiscal year shall be reflected in a subsequent year's prospective rate determination. Disallowances of nonreimbursable plant or capital, as appropriate, costs and NATCEPs costs shall be reflected in the year in which the nonreimbursable costs are included.

F. Effective July 1, 2001, for those NFs whose indirect operating cost rates are below the ceilings, an incentive plan shall be established whereby a NF shall be paid, on a sliding scale, up to 25% of the difference between its allowable indirect operating cost rates and the indirect peer group ceilings.

1. The following table presents four incentive examples:

| Peer Group Ceilings | Allowable Cost Per Day | Difference | % of Ceiling | Sliding Scale | Scale % Difference |
|---------------------|------------------------|------------|--------------|---------------|--------------------|
| \$30.00 | \$27.00 | \$3.00 | 10% | \$0.30 | 10% |
| 30.00 | 22.50 | 7.50 | 25% | 1.88 | 25% |
| 30.00 | 20.00 | 10.00 | 33% | 2.50 | 25% |
| 30.00 | 30.00 | 0 | 0 | | |

2. Efficiency incentives shall be calculated only for the indirect patient care operating ceilings and costs. Effective July 1, 2001, a direct care efficiency incentive shall no longer be paid.

G. Quality of care requirement. A cost efficiency incentive shall not be paid [~~to a NF for the prorated period of time that it is not in conformance with substantive, nonwaived life, safety, or quality of care standards for the number of days for which a facility is out of substantial compliance according to the Virginia Department of Health survey findings as based on federal regulations~~].

H. Sale of facility. In the event of the sale of a NF, the prospective base operating cost rates for the new owner's first fiscal period shall be the seller's prospective base operating cost rates before the sale.

I. Public notice. To comply with the requirements of § 1902(a)(28)(c) of the Social Security Act, DMAS shall make available to the public the data and methodology used in establishing Medicaid payment rates for nursing facilities. Copies may be obtained by request under the existing procedures of the Virginia Freedom of Information Act.

12 VAC 30-90-60. [No change from proposed.]

12 VAC 30-90-271. Direct patient care operating.

A. Nursing service expenses.

1. Salary--nursing administration. Gross salary (includes sick pay, holiday pay, vacation pay, staff development pay and overtime pay) of all licensed nurses in supervisory positions defined as follows (Director of Nursing, Assistant Director of Nursing, nursing unit supervisors [~~and~~], patient care coordinators [~~and MDS coordinators~~]).

2. Salaries--RNs. Gross salary of registered nurses.

3. Salaries--LPNs. Gross salary of licensed practical nurses.

4. Salaries--Nurse aides. Gross salary of certified nurse aides.

5. Salaries--Quality assurance nurses. Gross salary of licensed [~~nurse~~] nurses [~~who~~] [~~functions~~ function] as quality assurance [~~coordinator~~ coordinators] and [~~is~~ are] responsible for quality assurance activities and programs. Quality assurance activities and programs are concerned with resident care and not with the administrative support that is needed to document the care. If a quality assurance coordinator is employed by the home office and spends a percentage of time at nursing facilities, report directly

allocated costs to the nursing facility in this category rather than under the home office operating costs.

~~6.~~ 6. Nursing employee benefits. Benefits related to registered nurses, licensed practical nurses, certified nurse aides, *quality assurance nurses*, and nursing administration personnel as defined in subdivision 1 of this subsection. See 12 VAC 30-90-272 B for description of employee benefits.

~~6.~~ 7. Contract nursing services. Cost of registered nurses, licensed practical nurses, ~~and~~ certified nurse aides, *and quality assurance nurses* on a contract basis.

~~7.~~ 8. Supplies. Cost of supplies, including nursing and charting forms, medication and treatment records, physician order forms.

~~8.~~ 9. Professional fees. Medical director and pharmacy consultant fees.

B. Minor medical and surgical supplies.

1. Salaries--medical supply. Gross salary of personnel responsible for procurement, inventory and distribution of minor medical and surgical supplies.

2. Medical supply employee benefits. Benefits related to medical supply personnel. See 12 VAC 30-90-272 B for description of employee benefits.

3. Supplies. Cost of items for which a separate identifiable charge is not customarily made, including, but not limited to, colostomy bags; dressings; chux; rubbing alcohol; syringes; patient gowns; basins; bed pans; ice-bags and canes, crutches, walkers, wheel chairs, traction equipment and other durable medical equipment for multi-patient use.

4. Oxygen. Cost of oxygen for which a separate charge is not customarily made.

5. Nutrient/tube feedings. Cost of nutrients for tube feedings.

6. Incontinence services. Cost of disposable and nondisposable incontinence supplies. The laundry supplies or purchased commercial laundry service for nondisposable incontinent services.

C. Ancillary Service Cost. Allowable ancillary service costs represents gross salary and related employee benefits of those employees engaged in covered ancillary services to Medicaid recipients, cost of all supplies used by the respective ancillary service departments, cost of ancillary services performed on a contract basis by other than employees and all other costs allocated to the ancillary service cost centers in accordance with Medicare principles of reimbursement.

Following is a listing all covered ancillary services:

1. Radiology
2. Laboratory
3. [~~Inhalation~~ *Respiratory*] therapy
4. Physical therapy
5. Occupational therapy

6. Speech therapy

7. EKG

8. EEG

9. Medical supplies charged to patient

12 VAC 30-90-272. [No change from proposed.]

[12 VAC 30-90-280. Leasing of facilities.

The substance of this appendix shall apply only to Article 2 (12 VAC 30-90-30 et seq.) of Subpart II of Part II of this chapter.

I. Determination of allowable lease costs.

A. The provisions of this appendix shall apply to all lease agreements, including sales and leaseback agreements and lease purchase agreements, and including whether or not such agreements are between parties which are related (as defined in 12 VAC 30-90-50 of the Nursing Home Payment System (NHPS)).

B. Reimbursement of lease costs pursuant to a lease between parties which are not related shall be limited to the DMAS allowable cost of ownership as determined in subsection I E of this section. Reimbursement of lease costs pursuant to a lease between parties which are related (as defined in 12 VAC 30-90-50) shall be ~~limited~~ *adjusted* to the DMAS allowable cost of ownership. Whether the lease is between parties which are or are not related, the computation of the allowable annual lease expense shall be subject to DMAS audit.

C. The DMAS allowable cost of ownership shall be determined by the historical cost of the facility to the owner of record at the date the lease becomes effective. When a lease agreement is in effect, whether during the original term or a subsequent renewal, no increase in the reimbursement shall be allowed as a result of a subsequent sale of the facility.

D. When a bona fide sale has taken place, the facility must have been held by the seller for a period of no less than five years for a lease effected subsequent to the sale date to be compared to the buyer's cost of ownership. Where the facility has been held for less than five years, the allowable lease cost shall be computed using the seller's historical cost.

E. Reimbursement of lease costs pursuant to a lease between parties which are not related (as defined in 12 VAC 30-90-50) shall be limited to the DMAS allowable cost of ownership. The following reimbursement principles shall apply to leases, other than those covered in 12 VAC 30-90-50 and subsection IV of this appendix, entered into on or after October 1, 1990:

1. An "Allowable Cost of Ownership" schedule shall be created for the lease period to compare the total lease expense to the allowable cost of ownership.
2. If the lease cost for any cost reporting period is below the cost of ownership for that period, no adjustment shall be made to the lease cost, and a "carryover credit" to the extent of the amount allowable for that period under the "Allowable Cost of Ownership" schedule shall be created but not paid.

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3. If the lease cost for a future cost reporting period is greater than the "Cost of Ownership" for that period, the provider shall be paid this "carryover credit" from prior period(s), not to exceed the cumulative carryover credit or his actual lease cost, whichever is less. At no time during the lease period shall DMAS reimbursement exceed the actual cumulative "Cost of Ownership."

4. Once DMAS has determined the allowable cost of ownership, the provider shall be responsible for preparing a verifiable and auditable schedule to support cumulative computations of cost of ownership vs. lease cost to support the "carryover credit" as reported in the "Allowable Cost of Ownership" schedule, and shall submit such a schedule with each cost report.

II. Documentation of costs of ownership.

A. Leases shall provide that the lessee or DMAS shall have access to any and all documents required to establish the underlying cost of ownership.

B. In those instances where the lessor will not share this information with the lessee, the lessor can forward this information direct to DMAS for confidential review.

III. Computation of cost of ownership.

A. Before any rate determination for allowable lease costs is made, the lessee must supply a schedule comparing lease expense to the underlying cost of ownership for the life of the lease. Supporting documentation, including but not limited to, the lease and the actual cost of ownership (mortgage instruments, financial statements, purchase agreements, etc.) must be included with this schedule.

B. The underlying straight-line depreciation, interest, property taxes, insurance, and amortization of legal and commitment fees shall be used to determine the cost of ownership for comparison to the lease costs. Any cost associated with the acquisition of a lease other than those outlined herein shall not be considered allowable unless specifically approved by the Department of Medical Assistance Services.

1. Straight line depreciation.

a. Depreciation shall be computed on a straight line basis only.

b. New or additions facilities shall be depreciated in accordance with AHA Guidelines.

c. Allowable depreciation for on-going facilities shall be computed on the historical cost of the facility determined in accordance with limits on allowable building and fixed equipment cost.

d. The limits contained in 12 VAC 30-90-30, and Part VI (12 VAC 30-90-160) shall apply, as appropriate, whether the facility is newly constructed or an on-going facility.

2. Interest. Interest expense shall be limited to actual expense incurred by the owner of the facility in servicing long-term debt and shall be subject to the interest rate limitations stated in 12 VAC 30-90-30.

3. Taxes and insurance. Taxes are limited to actual incurred real estate and property taxes. Insurance is limited to the

actual cost of mortgage insurance, fire and property liability insurance. When included in the lease as the direct responsibility of the lessee, such taxes and insurance shall not be a part of the computation of the cost of ownership.

4. Legal and commitment fees. Amortization of actual incurred closing costs paid by the owner, such as attorney's fees, recording fees, transfer taxes and service or "finance" charges from the lending institution may be included in the comparison of the cost of ownership computation. Such fees shall be subject to limitations and tests of reasonableness stated in these regulations. These costs shall be amortized over the life of the mortgage.

5. Return on Equity.

a. Return on equity will be limited to the equity of the facility's owner when determining allowable lease expense. Return on equity shall be equal to the rental rate percentage used in connection with the fair rental value (FRV) methodology described in Article 3 (12 VAC 30-90-35 et seq.) of Subpart II of Part II of this chapter. For the purpose of determining allowable lease expense, equity will be computed in accordance with PRM-15 principles. The allowable base will be determined by monthly averaging of the annual equity balances. The base will be increased by the amount of paid up principal in a period but will be reduced by depreciation expense in that period.

b. Item 398D of the 1987 Appropriations Act (as amended), effective April 8, 1987 eliminated reimbursement of return on equity capital to proprietary providers for periods or portions thereof on or after July 1, 1987.

c. Leased facilities shall be eligible for return on equity capital after July 1, 2001, only if they were receiving return on equity capital on June 30, 2000.

IV. Leases approved prior to August 18, 1975.

A. Leases approved prior to August 18, 1975, shall have the terms of those leases honored for reimbursement throughout the duration of the lease.

B. Renewals and extensions to these leases shall be honored for reimbursement purposes only when the dollar amount negotiated at the time of renewal does not exceed the amount in effect at the termination date of the existing lease. No escalation clauses shall be approved.

C. Payments of rental costs for leases reimbursed pursuant to subsection IV A of this section shall be allowed whether the provider occupies the premises as a lessee, sublessee, assignee, or otherwise. Regardless of the terms of any present or future document creating a provider's tenancy or right of possession, and regardless of whether the terms thereof or the parties thereto may change from time to time, future reimbursement shall be limited to the lesser of ~~(4)~~ (i) the amount actually paid by the provider, or ~~(2)~~ (ii) the amount reimbursable by DMAS under these regulations as of ~~the effective date of this amendment~~ July 1, 2002. In the event extensions or renewals are approved pursuant to subsection IV B of this section, no escalation clauses shall be approved or honored for reimbursement purposes.

V. Nothing in this appendix shall be construed as assuring providers that reimbursement for rental costs will continue to be reimbursable under any further revisions of or amendment to these regulations.]

Appendix IV.

~~Class Resource Cost Assignment, Computation of Service Intensity Index and Ceiling And Rate Adjustments to the Prospective Direct Patient Care Operating Cost Rate; Allowance for Inflation Methodology Base "Current" Operating Rate Resource Utilization Groups (RUGs).~~

12 VAC 30-90-300 through 12 VAC 30-90-304. [No change from proposed.]

12 VAC 30-90-305. Resource Utilization Groups (RUGs).

A. The Resource Utilization Groups-III (RUG-III), Version 5.12, 34-group, index maximizing model shall be used as the resident classification system to determine the RUG-III group for each resident assessment. RUG-III classifies resident assessments according to the intensity of each resident's needs. Data from the minimum data set (MDS) submitted by each facility to the Centers for Medicare and Medicaid Services (CMS) shall be used to classify the resident assessments into RUG-III groups.

B. Definitions. The following words and terms when used in this appendix shall have the following meanings unless the context clearly indicates otherwise.

"Base year" means the calendar year for which the most recent reliable nursing facility [cost settled] cost reports are available in the DMAS database as of September 1 of the year prior to the year in which the rebased rates will be used. (See also definition of rebasing.)

"Case-mix index (CMI)" means a numeric score that identifies the relative resources used by similar residents and represents the average resource consumption of those residents.

"Case-mix neutralization" means the process of removing cost variations for direct patient care costs associated with different levels of resident case mix.

"Day-weighted median" means a weighted median where the weight is Medicaid days.

"Medicaid average case-mix index" means a simple average, carried to four decimal places, of all resident case mix indices where Medicaid is known to be the per diem payor source on the last day of the calendar quarter.

"Minimum data set (MDS)" means a federally required resident assessment instrument. Information from the MDS is used to determine the facility's case-mix index.

"Normalization" means the process by which the average case mix for the state is set to 1.0.

"Nursing facility" means a facility, not including intermediate care facilities for the mentally retarded, licensed by the Department of Health and certified as meeting the participation requirements of the Medicaid program.

"Rebasing" means the process of updating cost data used to calculate peer group ceilings for subsequent base years.

12 VAC 30-90-306. Case-mix index (CMI).

A. Each resident in a Virginia Medicaid certified nursing facility on the last day of the calendar quarter with an effective assessment date during the respective quarter shall be assigned to one of the RUG-III 34-groups.

B. Standard case-mix indices, developed by CMS for the Medicaid population (B01), shall be assigned to each of the RUG-III 34 groups [as indicated in Table III].

[Table III
Case Mix Indices (CMI)

| RUG Category | RUG Description | CMS "Standard" B01 CMI Set |
|--------------|--|----------------------------|
| RAD | Rehabilitation All Levels / ADL 17-18 | 1.66 |
| RAC | Rehabilitation All Levels / ADL 14-16 | 1.31 |
| RAB | Rehabilitation All Levels / ADL 9-13 | 1.24 |
| RAA | Rehabilitation All Levels / ADL 4-8 | 1.07 |
| SE3 | Extensive Special Care 3 / ADL >6 | 2.10 |
| SE2 | Extensive Special Care 2 / ADL >6 | 1.79 |
| SE1 | Extensive Special Care 1 / ADL >6 | 1.54 |
| SSC | Special Care / ADL 17-18 | 1.44 |
| SSB | Special Care / ADL 15-16 | 1.33 |
| SSA | Special Care / ADL 4-14 | 1.28 |
| CC2 | Clinically Complex with Depression / ADL 17-18 | 1.42 |
| CC1 | Clinically Complex / ADL 17-18 | 1.25 |
| CB2 | Clinically Complex with Depression / ADL 12-16 | 1.15 |
| CB1 | Clinically Complex / ADL 12-16 | 1.07 |
| CA2 | Clinically Complex with Depression / ADL 4-11 | 1.06 |
| CA1 | Clinically Complex / ADL 4-11 | 0.95 |
| IB2 | Cognitive Impairment with Nursing Rehab / ADL 6-10 | 0.88 |
| IB1 | Cognitive Impairment / ADL 6-10 | 0.85 |
| IA2 | Cognitive Impairment with Nursing Rehab / ADL 4-5 | 0.72 |
| | Cognitive Impairment / ADL 4-5 | 0.67 |
| BB2 | Behavior Problem with Nursing Rehab / ADL 6-10 | 0.86 |
| BB1 | Behavior Problem / ADL 6-10 | 0.82 |
| BA2 | Behavior Problem with Nursing Rehab / ADL 4-5 | 0.71 |

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| | | |
|-----|--|-------|
| BA1 | Behavior Problem / ADL 4-5 | 0.60 |
| PE2 | Physical Function with Nursing Rehab / ADL 16-18 | 1.00 |
| PE1 | Physical Function / ADL 16-18 | 0.97 |
| PD2 | Physical Function with Nursing Rehab / ADL 11-15 | 0.91 |
| PD1 | Physical Function / ADL 11-15 | 0.89 |
| PC2 | Physical Function with Nursing Rehab / ADL 9-10 | 0.83 |
| PC1 | Physical Function / ADL 9-10 | 0.81 |
| PB2 | Physical Function with Nursing Rehab / ADL 6-8 | 0.65 |
| PB1 | Physical Function / ADL 6-8 | 0.63 |
| PA2 | Physical Function with Nursing Rehab / ADL 4-5 | 0.62 |
| PA1 | Physical Function / ADL 4-5 | 0.59] |

C. There shall be four "picture dates" for each calendar year: March 31, June 30, September 30 and December 31. Each resident in each Medicaid-certified nursing facility on the picture date with a completed assessment that has an effective assessment date within the [~~preceding~~] quarter shall be assigned a case-mix index based on the resident's most recent assessment for the picture date as available in the DMAS MDS database.

D. Using the individual Medicaid resident case-mix indices, a facility average Medicaid case-mix index shall be calculated four times per year for each facility. The facility average Medicaid case-mix indices shall be used for case-mix neutralization of resident care costs and for case-mix adjustment.

1. During the time period beginning with the implementation of RUG-III up to the ceiling and rate setting effective July 1, 2004, the case-mix index calculations shall be based on assessments for residents for whom Medicaid is the principal payer. The statewide average Medicaid case-mix index shall be a simple average, carried to four decimal places, of all case-mix indices for nursing facility residents in Virginia Medicaid certified nursing facilities for whom Medicaid is the principal payer on the last day of the calendar quarter. The facility average Medicaid case-mix index shall be a simple average, carried to four decimal places, of all case-mix indices for nursing facility residents in the Virginia Medicaid-certified nursing facility for whom Medicaid is the principal payer on the last day of the calendar quarter.

2. The facility average Medicaid case-mix index shall be normalized across all of Virginia's Medicaid-certified nursing facilities for each picture date. To normalize the facility average Medicaid case-mix index, the facility average Medicaid case-mix index is divided by the statewide average Medicaid case-mix index for the same picture date.

3. The department shall monitor the case-mix [, including the case mix normalization and the neutralization processes,] indices during the first two years following implementation of the RUG-III system. Effective July 1, 2004, the statewide average case-mix index may be changed to recognize the fact that the costs of all residents are related to the case mix of all residents. The statewide average case-mix index of all residents, regardless of principal payer on the effective date of the assessment, in a Virginia Medicaid certified nursing facility may be used for case-mix neutralization. The use of the facility average Medicaid case-mix index to adjust the prospective rate would not change.

4. There shall be a correction period for Medicaid-certified nursing facilities to submit correction assessments to the CMS MDS database following each picture date. A report that details the picture date RUG category and CMI score for each resident in each nursing facility shall be mailed to the facility for review. The nursing facility shall have a 30-day time period to submit any correction assessments to the MDS database or to contact the Department of Medical Assistance Services regarding other corrections. Corrections submitted in the 30-day timeframe shall be included in the final report of the CMI scores that shall be used in the calculation of the nursing facility ceilings and rates. Any corrections submitted after the 30-day timeframe shall not be included in the final report of the CMI scores that shall be used in the calculation of the nursing facility ceilings and rates.

5. Assessments that cannot be classified to a RUG-III group due to errors shall be assigned the lowest case-mix index score.

6. Assessments shall not be used for any out-of-state nursing facility provider that is enrolled in the Virginia Medical Assistance Program and is required to submit cost reports to the Medicaid program.

12 VAC 30-90-307. Applicability of case-mix indices (CMI).

A. The CMI shall be used to adjust the direct patient care cost ceilings and rates for application to individual nursing facilities. Indirect patient care cost ceilings and rates shall not be case-mix adjusted. The CMI shall be calculated using MDS data taken from picture dates as specified in this section.

B. When a facility's direct patient care cost ceiling is compared to its facility specific direct patient care cost rate to determine the direct patient care prospective rate, both the ceiling and the rate shall be case-mix neutral. The direct patient care cost ceiling shall be case-mix neutral because it shall be calculated using base year facility direct patient care cost data that have been case-mix neutralized. To accomplish this neutralization, each facility's base year direct patient care operating cost shall be divided by the facility's average normalized Medicaid CMI developed for the two semiannual periods of assessment data that most closely match the provider's cost reporting year that ends in the base year (see Table [~~##~~ IV] below). This shall be the facility's case-mix neutral direct patient care per diem for the base year and shall be used in the calculation of the peer group direct patient care cost ceilings. Table [~~##~~ IV] shows an example of the picture dates used to case-mix

neutralize facility specific direct costs for the ceiling calculation. For the first few provider fiscal years for which cost neutralization will be done, a data limitation affects the picture dates that can be used. Accurate case-mix data are available starting with the fourth quarter of calendar year (CY) 1999. For providers with cost reporting periods ending during the first, second, and third quarters of CY 2000, the picture dates used in cost neutralization shall be modified to reflect only accurate case-mix data. For provider cost reporting periods ending in the fourth quarter of 2000 and afterward, this limitation no longer exists and assessment data shall be used that most closely match the cost reporting period.

Table [## IV]

| Quarter of Provider Cost Report Year End | Picture Dates Used to Neutralize Costs for Ceiling Calculation | |
|--|--|---|
| | Preferred Picture Dates if No Data Limitation Applied | Picture Dates That Shall be Used Due to Data Limitation |
| First Quarter of CY 2000 | 3/31/99, 6/30/99, 9/30/99, 12/31/99 | 12/31/99 |
| Second Quarter of CY 2000 | 6/30/99, 9/30/99, 12/31/99, 3/31/00 | 12/31/99, 3/31/00 |
| Third Quarter of CY 2000 | 9/30/99, 12/31/99, 3/31/00, 6/30/00 | 12/31/99, 3/31/00, 6/30/00 |
| Fourth Quarter of CY 2000 | 12/31/99, 3/31/00, 6/30/00, 9/30/00 | 12/31/99, 3/31/00, 6/30/00, 9/30/00 |

C. When direct patient care prospective rates are set, the direct patient care ceilings used in the calculation shall be the case-mix neutralized ceiling described in subsection B of this section, adjusted for inflation to the midpoint of the prospective period. However, the facility-specific direct patient care cost rates used in the calculation shall not be from the base year, but shall be from the provider fiscal year prior to the period for which a prospective rate is being calculated. Therefore, the provider's direct patient care rate from the previous cost reporting period shall be case-mix neutralized using the facility average normalized Medicaid CMI developed for the two semiannual periods of assessment data that most closely match the cost reporting period prior to the prospective period for which a rate is being calculated. Each year when a new prospective rate is developed, the provider specific direct patient care rate shall be case-mix neutralized using CMI data that uses picture dates that correspond to the cost reporting period used to develop the rate. The relationship between provider cost reporting period and picture dates shall be that illustrated in Table [## IV] , except that in the time period when rates will first be set, the data limitation that affected the picture dates shown in Table [## IV] will not apply. Therefore, for all provider cost reporting periods, picture dates that correspond to the cost reporting period shall be used.

D. After the case-mix neutral direct patient care ceiling (adjusted for inflation from the base year to the prospective period) is compared to the case-mix neutralized facility-specific direct patient care rate (adjusted for inflation from the previous cost reporting period to the prospective period), the lower of the two shall be chosen. This lower amount shall be

the case-mix neutral prospective rate per diem for the prospective period. It shall then be adjusted for the CMI intended to correspond as closely as possible to the prospective period. Because of the manner in which the necessary data are reported, there shall be a lag between the picture dates used to develop the CMI information and the prospective period to which the CMI shall apply. The relationship between picture dates and prospective rate periods is illustrated in Table [## V].

Table [## V]

Example of Picture Dates Used in Case-Mix Adjustment of Prospective Rate

| Quarter of Provider Cost Report Year End | Picture Dates Used to Adjust First Prospective Semiannual Period | Picture Dates Used to Adjust Second Prospective Semiannual Period |
|--|--|---|
| First Quarter CY 2002 | 9/30/01, 12/31/01 | 3/31/02, 6/30/02 |
| Second Quarter CY 2002 | 12/31/01, 3/31/02 | 6/30/02, 9/30/02 |
| Third Quarter CY 2002 | 3/31/02, 6/30/02 | 9/30/02, 12/31/02 |
| Fourth Quarter CY 2002 | 6/30/02, 9/30/02 | 12/31/02, 3/31/03 |

E. Any out-of-state nursing facility provider that is enrolled in the Virginia Medical Assistance Program and is required to submit a cost report to the Virginia Medical Assistance Program will be assigned the Virginia statewide normalized CMI of 1.0. This CMI of 1.0 will be used to adjust the direct patient care cost ceilings and rates.

F. Example of case-mix adjustment of direct operating rate.

1. Following is an illustration of how a nursing facility's case-mix index is used to make direct patient care semiannual rate adjustments to the prospective direct patient care operating cost base rate.

2. Assumptions.

- The nursing facility's fiscal year is January 1, 2002, through December 31, 2002.
- The average allowable direct patient care operating rate for the year is \$50.
- The allowance for inflation is 4.0% for the fiscal year beginning January 1, 2003.
- The nursing facility's case-mix neutral direct peer group ceiling for the fiscal year beginning January 1, 2003, is \$60.
- The nursing facility's normalized case-mix scores are as follows:

| | |
|-----------------------------|--------|
| 12/31/2001 picture date CMI | 1.0100 |
| 3/31/2002 picture date CMI | 1.0105 |
| 6/30/2002 picture date CMI | 1.0098 |
| 9/30/2002 picture date CMI | 1.0305 |
| 12/31/2002 picture date CMI | 1.0355 |
| 3/31/2003 picture date CMI | 1.0400 |

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3. Calculation of nursing facility's Direct Patient Care Operating Cost Rate.

a. Direct Patient Care Operating Cost Rate:

| | |
|--|------|
| Average Allowable Direct Patient Care Operating Rate | \$50 |
| Allowance For Inflation FYE 2003 x 1.0400 | \$52 |

b. Calculation of case-mix factor used for case-mix neutralization:

| | |
|-----------------------|--------|
| 12/31/2001 CMI | 1.0100 |
| 3/31/2002 CMI | 1.0105 |
| 6/30/2002 CMI | 1.0098 |
| 9/30/2002 CMI | 1.0305 |
| Average of four CMI = | 1.0152 |

c. Case-mix neutralized average allowable direct patient care operating rate: Average Allowable Direct Patient Care Operating Rate for FY 2003

| | |
|---|---------|
| Case-mix neutralization factor | 1.0152 |
| Case-mix neutralized Direct Patient Care Operating Rate for FY 2003 = | \$51.22 |

d. Lower of case-mix neutralized cost or ceiling:

The case-mix neutralized Direct Patient Care Operating Rate, \$51.22, is lower than the case-mix neutral ceiling, \$60. \$51.22 will be used in the rate calculation.

e. Calculation of case-mix rate adjustments:

(1) Case-mix rate adjustment for the period January 1, 2003, through June 30, 2003:

First semiannual rate adjustment – Average of (6/30/2002 CMI, 9/30/2002 CMI) = Average(1.0098, 1.0305) = 1.0202

(2) Case-mix rate adjustment for the period July 1, 2003 through December 31, 2003:

Second semiannual rate adjustment – Average of (12/31/2002 CMI, 3/31/2003 CMI) = Average(1.0355, 1.0400) = 1.0378

f. Rates for semiannual periods:

(1) Case-mix adjusted rate for the period January 1, 2003, through June 30, 2003:

First semiannual rate = 1.0202 * \$51.22 = \$52.25

(2) Case-mix adjusted rate for the period July 1, 2003 through December 31, 2003:

Second semiannual rate = 1.0378 * \$51.22 = \$53.15

FORMS [No change from proposed.]

VA.R. Doc. No. R01-176; Filed May 1, 2002, 9:36 a.m.

STATE BOARD OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

Title of Regulation: 12 VAC 35-102. Rules and Regulations for the Licensure of Facilities and Providers of Mental Health, Mental Retardation and Substance Abuse Services (REPEALED).

Title of Regulation: 12 VAC 35-105. Rules and Regulations for the Licensing of Providers of Mental Health, Mental Retardation and Substance Abuse Services (adding 12 VAC 35-105-10 through [~~12 VAC 35-105-1440~~ 12 VAC 35-105-1410]).

Title of Regulation: 12 VAC 35-170. Regulations for the Certification of Case Management (REPEALED).

Statutory Authority: §§ 37.1-179.1 and 37.1-182 of the Code of Virginia.

Effective Date: September 19, 2002.

Summary:

The regulatory action repeals the existing licensure regulation (12 VAC 35-102) and case management certification regulation (12 VAC 35-170) and replaces them with a new regulation (12 VAC 35-105). The new regulation:

1. Incorporates the process for licensing, including the issuance of variances and sanctions, into the text of this chapter;

2. Reflects recent changes in statute (background checks on staff, compliance with human rights regulations, licensing of case management and gero-psychiatric residential services);

3. Raises program director and supervisor qualifications and more clearly states requirements for orientation and retraining of employees;

4. Establishes requirements for earlier assessments and service planning and sets more specific requirements to fulfill the current expectation that programs be able to adequately respond and care for the medical needs of individuals receiving services;

5. Provides more specific requirements concerning physical environment standards (quantifies "acceptable" room and water temperatures) and eliminates the separate facility license;

6. Requires physical separation for children and adults in residential and inpatient programs;

7. Sets a maximum limit of 20 beds for licensing as an intermediate care facility for the mentally retarded (ICF/MR);

8. Addresses additional types of services offered by providers (sponsored residential home services, intensive community treatment programs, programs of assertive community treatment services); and

9. Updates the opioid treatment and detoxification services sections to reflect new federal regulations and conform to current practice standards.

The following revisions were made to the proposed regulations as a result of public comments:

1. Modification of definitions to clarify meanings;
2. Deletion of the list of persons or organizations that are not required to be licensed;
3. Amendments for sewer and water inspections;
4. Revision to the weapons section;
5. Removal of the specific requirement for changing bed linen every seven days;
6. Revision of criminal history background check section to comply with current statute;
7. Change in requirement for orientation of new employees from 14 calendar days to 15 business days;
8. Modification of tuberculosis (TB) screening;
9. Reduction in the number of required drug screens in opioid treatment services from 12 to eight;
10. Deletion of the regulatory requirements and the references to sobering-up centers; and
11. Modification of Program of Assertive Community Treatment (PACT) regulations significantly based on the national model.

Summary of Public Comments and Agency Response: A summary of comments made by the public and the agency's response may be obtained from the promulgating agency or viewed at the office of the Registrar of Regulations.

Agency Contact: Leslie Anderson, Director, Office of Licensing, Department of Mental Health, Mental Retardation and Substance Abuse Services, P.O. Box 1797, Richmond, VA 23218-1797, telephone (804) 371-6885, FAX (804) 692-0066.

CHAPTER 105.

RULES AND REGULATIONS FOR THE LICENSING OF PROVIDERS OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES.

PART I.

GENERAL PROVISIONS.

Article 1.

Authority and Applicability.

12 VAC 35-105-10. Authority and applicability.

A. Section 37.1-179.1 of the Code of Virginia authorizes the commissioner to license providers subject to rules and regulations promulgated by the State Mental Health, Mental Retardation and Substance Abuse Services Board.

B. No [~~person or organization, except as provided for in subsection C of this section, may provide care or treatment~~ provider shall establish, maintain, conduct or operate any service] for persons with mental illness or mental retardation or persons [~~addicted to the intemperate use of narcotic drugs, alcohol or other stimulants including the detoxification, treatment or rehabilitation of drug addicts through the use of~~

~~opioid treatment with substance addiction or abuse] without first receiving a license from the commissioner.~~

[~~C. The following persons or organizations are not required to be licensed:~~

- ~~1. An organization operated by the federal government;~~
- ~~2. An organization operated by the Department of Mental Health, Mental Retardation and Substance Services;~~
- ~~3. An organization operated or funded by the Department of Rehabilitative Services;~~
- ~~4. An organization licensed by the Department of Health that does not provide inpatient psychiatric or substance abuse services in a special unit in a hospital as defined in § 32.1-123 of the Code of Virginia;~~
- ~~5. An organization operated by the Department of Education, licensed by the Department of Education, or operated by a local school division;~~
- ~~6. An organization licensed by the Department of Social Services;~~
- ~~7. An organization licensed under the Standards for Interdepartmental Regulation of Children's Residential Facilities (22 VAC 42-10) by the Department of Social Services, the Department of Juvenile Justice, or the Department of Education;~~
- ~~8. An individual practitioner who is licensed or certified under Title 54.1 of the Code of Virginia or who is otherwise legally authorized to render professional services within this Commonwealth and who is providing services within the scope and limits of his license or certification;~~
- ~~9. A private practice group as defined in these regulations; and~~
- ~~10. An organization practicing the religious tenets of any church in the ministration to the sick and suffering by mental or spiritual means without the use of any drug or material remedy, whether gratuitously or for compensation.]~~

Article 2.

Definitions.

12 VAC 35-105-20. Definitions.

The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Abuse" (§ 37.1-1 of the Code of Virginia) means any act or failure to act, by an employee or other person responsible for the care of an individual receiving services that was performed or was failed to be performed knowingly, recklessly, or intentionally, and that caused or might have caused physical or psychological harm, injury, or death to an individual receiving services. Examples of abuse include, but are not limited to, the following:

1. Rape, sexual assault, or other criminal sexual behavior;
2. Assault or battery;

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3. Use of language that demeans, threatens, intimidates or humiliates the person;

4. Misuse or misappropriation of the person's assets, goods or property;

5. Use of excessive force when placing a person in physical or mechanical restraint;

6. Use of physical or mechanical restraints on a person that is not in compliance with federal and state laws, regulations, and policies, professional accepted standards of practice or the person's individual service plan;

7. Use of more restrictive or intensive services or denial of services to punish the person or that is not consistent with his individual service plan.

"Admission" means the process of acceptance into a service that includes orientation to service goals, rules and requirements, and assignment to appropriate employees.

"Behavior management" means those principles and methods employed by a provider to help an individual receiving services to achieve a positive outcome and to address and correct inappropriate behavior in a constructive and safe manner. Behavior management principles and methods must be employed in accordance with the individualized service plan and written policies and procedures governing service expectations, treatment goals, safety and security.

"Behavioral treatment program" means any set of documented procedures that are an integral part of the interdisciplinary treatment plan and are developed on the basis of a systemic data collection such as a functional assessment for the purpose of assisting an individual receiving services to achieve any or all of the following: (i) improved behavioral functioning and effectiveness; (ii) alleviation of the symptoms of psychopathology; or (iii) reduction of serious behaviors. A behavioral treatment program can also be referred to as a behavioral treatment plan or behavioral support plan.

"Care" or "treatment" means a set of individually planned interventions, training, habilitation, or supports that help an individual obtain or maintain an optimal level of functioning, reduce the effects of disability or discomfort, or ameliorate symptoms, undesirable changes or conditions specific to physical, mental, behavioral, or social functioning.

"Case management service" means assisting individuals and their families to access services and supports that are essential to meeting their basic needs identified in their individualized service plan, which include not only accessing needed mental health, mental retardation and substance abuse services, but also any medical, nutritional, social, educational, vocational and employment, housing, economic assistance, transportation, leisure and recreational, legal, and advocacy services and supports that the individual needs to function in a community setting. [Maintaining waiting lists for services, case management tracking and periodically contacting individuals for the purpose of determining the potential need for services shall be considered screening and referral and not admission into licensed case management.]

"Clubhouse service" means the provision of recovery-oriented psychosocial rehabilitation services in a nonresidential setting

on a regular basis not less than two hours per day, five days per week, in which clubhouse members and employees work together in the development and implementation of structured activities involved in the day-to-day operation of the clubhouse facilities and in other social and employment opportunities through skills training, peer support, vocational rehabilitation, and community resource development.

"Commissioner" means the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services or his authorized agent.

"Community gero-psychiatric residential services" means 24-hour nonacute care in conjunction with treatment in a setting that provides less intensive services than a hospital, but more intensive mental health services than a nursing home or group home. Individuals with mental illness, behavioral problems, and concomitant health problems (usually age 65 and older), appropriately treated in a geriatric setting, are provided intense supervision, psychiatric care, behavioral treatment planning, nursing, and other health related services. An Interdisciplinary Services Team assesses the individual and develops the services plan.

"Community intermediate care facility/mental retardation (ICF/MR)" means a service licensed by the Department of Mental Health, Mental Retardation, and Substance Abuse Services in which care is provided to individuals who [~~are mentally retarded~~ have mental retardation] who are not in need of nursing care, but who need more intensive training and supervision than may be available in an assisted living facility or group home. Such facilities must comply with Title XIX of the Social Security Act standards, provide health or rehabilitative services, and provide active treatment to individuals receiving services toward the achievement of a more independent level of functioning or an improved quality of life.

"Complaint" means an allegation brought to the attention of the department that a licensed provider violated these regulations.

"Corrective action plan" means the provider's pledged corrective action in response to noncompliances documented by the regulatory authority. A corrective action plan must be completed within a specified time.

"Correctional facility" means a facility operated under the management and control of the Virginia Department of Corrections.

"Corporal punishment" means punishment administered through the intentional inflicting of pain or discomfort to the body (i) through actions such as, but not limited to, striking or hitting with any part of the body or with an implement; (ii) through pinching, pulling or shaking; or (iii) through any similar action that normally inflicts pain or discomfort.

"Crisis" means a situation in which an individual presents an immediate danger to self or others or is at risk of serious mental or physical health deterioration.

"Day support service" means the provision of individualized planned activities, supports, training, supervision, and transportation to individuals with mental retardation to improve functioning or maintain an optimal level of functioning.

Services may enhance the following skills: self-care and hygiene, eating, toileting, task learning, community resource utilization, environmental and behavioral skills, medication management, and transportation. Services may be provided in a facility (center based) or provided out in the community (noncenter based). Services are provided for two or more consecutive hours per day. The term "day support service" does not include services in which the primary function is to provide extended sheltered or competitive employment, supported or transitional employment services, general education services, general recreational services, or outpatient services licensed pursuant to this chapter.

"Day treatment services" means the provision of coordinated, intensive, comprehensive, and multidisciplinary treatment to individuals through a combination of diagnostic, medical, psychiatric, case management, psychosocial rehabilitation, prevocational and educational services. Services are provided for two or more consecutive hours per day.

"Department" means the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services.

"Discharge" means the process by which the individual's active involvement with a provider is terminated by the provider.

"Discharge plan" means the written plan that establishes the criteria for an individual's discharge from a service and coordinates planning for aftercare services.

"Dispense" means to deliver a drug to an ultimate user by or pursuant to the lawful order of a practitioner, including the prescribing and administering, packaging, labeling or compounding necessary to prepare the substance for that delivery. (§ 54.1-3400 et seq. of the Code of Virginia.)

"Emergency service" means mental health, mental retardation or substance abuse services available 24 hours a day and seven days per week that provide crisis intervention, stabilization, and referral assistance over the telephone or face-to-face for individuals seeking services for themselves or others. Emergency services may include walk-ins, home visits, jail interventions, pre-admission screenings, and other activities designed to stabilize an individual within the setting most appropriate to the individual's current condition.

"Group home residential service" means a [congregate] residential service providing 24-hour supervision in a community-based, home-like dwelling [, other than the private home of the operator]. These services are provided for individuals needing assistance [, counseling,] and training in activities of daily living or whose service plan identifies the need for the specific type of supervision [or counseling] available in this setting.

"Home and noncenter based" means that a service is provided in the home or other noncenter-based setting. This includes but is not limited to noncenter-based day support, supportive [residential in-home], and intensive in-home services.

"Individual" or "individual receiving services" means a person receiving care or treatment or other services from a provider licensed under this chapter whether that person is referred to as a patient, client, resident, student, individual, recipient, family member, relative, or other term. When the term is used,

the requirement applies to every individual receiving services of the provider.

"Individualized services plan" or "ISP," means a comprehensive and regularly updated written plan of action to meet the needs and preferences of an individual.

"Inpatient psychiatric service" means a 24-hour intensive medical, nursing care and treatment provided for individuals with mental illness or problems with substance abuse in a hospital as defined in § 32.1-123 of the Code of Virginia or in a special unit of such a hospital.

"Intensive Community Treatment (ICT) service" means a [comprehensive combination of outpatient and mental health community support services provided by a self-contained community-based services team composed of clinical employees, including at least one nurse, mental health professionals, and one or more psychiatrists. The ICT Team provides needed treatment, rehabilitation, and support services to people with serious and persistent mental illness. Most ICT services are delivered one-on-one to the individual in the community. self-contained interdisciplinary team of at least five full-time equivalent clinical staff, a program assistant, and a full-time psychiatrist that:

1. Assumes responsibility for directly providing needed treatment, rehabilitation, and support services to identified individuals with severe and persistent mental illnesses;
2. Minimally refers individuals to outside service providers;
3. Provides services on a long-term care basis with continuity of caregivers over time;
4. Delivers 75% or more of the services outside program offices; and
5. Emphasizes outreach, relationship building, and individualization of services.

The individuals to be served by ICT are individuals who have severe symptoms and impairments not effectively remedied by available treatments or who, because of reasons related to their mental illness, resist or avoid involvement with mental health services.]

"Intensive in-home service" means [time-limited] family preservation interventions for children and adolescents who have or are at-risk of serious emotional disturbance, including such individuals who also have a diagnosis of mental retardation. Services are [usually time limited] provided typically in the residence of an individual who is at risk of being moved to out-of-home placement or who is being transitioned back home from an out-of-home placement. These services include crisis treatment; individual and family counseling; life, parenting, and communication skills; case management activities and coordination with other services; and emergency response.

"Intensive outpatient service" means treatment provided in a concentrated manner ([several hours per day involving multiple outpatient visits] per week) over a [limited] period of time for individuals requiring stabilization. These services usually include multiple group therapy sessions during the

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week, individual and family therapy, individual monitoring, and case management.

"Investigation" means a detailed inquiry or systematic examination of the operations of a provider or its services regarding a violation of regulations or law. An investigation may be undertaken as a result of a complaint, an incident report or other information that comes to the attention of the department.

"Legally authorized representative" means a person permitted by law [~~or this chapter~~] to give informed consent for disclosure of information and give informed consent to treatment, including medical treatment, and participation in human research for an individual who lacks the mental capacity to make these decisions.

"Licensed mental health professional (LMHP)" means a physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed substance abuse treatment [~~provider practitioner~~], or [~~licensed certification as a~~] psychiatric clinical nurse specialist.

"Location" means a place where services are or could be provided.

"Medical detoxification" means a service provided in a hospital or other 24-hour care facility, under the supervision of medical personnel using medication to systematically eliminate or reduce effects of alcohol or other drugs in the body.

"Medical evaluation" means the process of assessing an individual's health status that includes a medical history and a physical examination of [~~the an~~] individual conducted by a licensed medical practitioner operating within the scope of his license.

"Medication" means prescribed or over-the-counter drugs or both.

"Medication administration" means the direct application of medications by injection, inhalation, or ingestion or any other means to an individual receiving services by (i) persons legally permitted to administer medications or (ii) the individual at the direction and in the presence of persons legally permitted to administer medications [~~(§ 54.1-3401 of the Code of Virginia)~~].

"Medication error" means that an error has been made in administering a medication to an individual when any of the following occur: (i) the wrong medication is given to an individual, (ii) the wrong individual is given the medication, (iii) the wrong dosage is given to an individual, (iv) medication is given to an individual at the wrong time or not at all, or (v) the proper method is not used to give the medication to the individual.

["Medication storage" means any area where medications are maintained by the provider, including a locked cabinet, locked room, or locked box.]

"Mental Health Community Support Service (MHCSS)" means [~~a comprehensive combination of case management services and psychosocial rehabilitation that is provided in accordance with a psychosocial rehabilitation service plan~~] the provision of recovery-oriented psychosocial rehabilitation services to

individuals with long-term, severe psychiatric disabilities including skills training and assistance in accessing and effectively utilizing services and supports that are essential to meeting the needs identified in their individualized service plan and development of environmental supports necessary to sustain active community living as independently as possible]. MHCSS Services are provided in any setting in which the individual's needs can be addressed, skills training applied, and recovery experienced.

[~~"Mental illness means mental disorder or functioning classifiable under the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association that affects the well-being or behavior of an individual to such an extent that for his own welfare or the welfare of others, he requires care and treatment."~~]

"Mental retardation" means substantial subaverage general intellectual functioning that originates during the development period [~~, existing~~] and is associated with impairment in adaptive behavior. It exists [] concurrently with related limitations in two or more of the following applicable adaptive skill areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work.

["Mentally ill" means any person afflicted with mental disease to such an extent that for his own welfare or the welfare of others he requires care and treatment, or with mental disorder or functioning classifiable under the diagnostic criteria from the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Fourth Edition, 1994, that affects the well-being or behavior of an individual.]

"Neglect" means the failure by an individual or provider responsible for providing services to provide nourishment, treatment, care, goods, or services necessary to the health, safety or welfare of a person receiving care or treatment for mental illness, mental retardation or substance abuse (§ 37.1-1 of the Code of Virginia).

"Opioid treatment service" means an intervention strategy that combines [~~outpatient~~] treatment with the administering or dispensing of opioid agonist treatment medication. An individual-specific, physician-ordered dose of medication is administered or dispensed either for detoxification or maintenance treatment.

"Outpatient service" means a variety of treatment interventions generally provided to individuals, groups or families on an hourly schedule in a clinic or similar facility or in another location. Outpatient services include, but are not limited to, emergency services, crisis intervention services, diagnosis and evaluation, intake and screening, counseling, psychotherapy, behavior management, psychological testing and assessment, chemotherapy and medication management services, and jail based services. "Outpatient service" specifically includes:

1. Services operated by a community services board established pursuant to Chapter 10 (§ 37.1-194 et seq.) of Title 37.1 of the Code of Virginia;
2. Services funded wholly or in part, directly or indirectly, by a community services board established pursuant to

Chapter 10 (§ 37.1-194 et seq.) of Title 37.1 of the Code of Virginia; or

3. Services that are owned, operated, or controlled by a corporation organized pursuant to the provisions of either Chapter 9 (§ 13.1-601 et seq.) or Chapter 10 (§ 13.1-801 et seq.) of Title 13.1 of the Code of Virginia.

"Partial hospitalization service" means the provision within a medically supervised setting of day treatment services that are time-limited active treatment interventions, more intensive than outpatient services, designed to stabilize and ameliorate acute symptoms, and serve as an alternative to inpatient hospitalization or to reduce the length of a hospital stay.

"Program of Assertive Community Treatment (PACT) service" means ~~[an intensive community treatment service provided with more enriched staffing levels than are provided through an ICT, a self-contained interdisciplinary team of at least 10 full-time equivalent clinical staff, a program assistant, and a full- or part-time psychiatrist that:~~

1. Assumes responsibility for directly providing needed treatment, rehabilitation, and support services to identified individuals with severe and persistent mental illnesses;
2. Minimally refers individuals to outside service providers;
3. Provides services on a long-term care basis with continuity of caregivers over time;
4. Delivers 75% or more of the services outside program offices; and
5. Emphasizes outreach, relationship building, and individualization of services.

The individuals to be served by PACT are individuals who have severe symptoms and impairments not effectively remedied by available treatments or who, because of reasons related to their mental illness, resist or avoid involvement with mental health services.]

~~["Private practice group" means one or more practitioners who are individually licensed or certified under the provisions of Title 54.1 of the Code of Virginia and their employees who are individually licensed or certified under the provisions of Title 54.1 of the Code of Virginia or who are otherwise legally authorized to render professional services within this Commonwealth, who have for purposes of convenience or efficiency associated or grouped themselves through the use of shared office space or administrative support in order to provide professional services within the scope and limits of their individual and respective professional licenses or certifications, whether the association is informal or has been formalized through a legally established organization such as a professional corporation organized pursuant to the provisions of Chapter 7 (§ 13.1-542 et seq.) of Title 13.1 of the Code of Virginia, or a general partnership organized under the provisions of Chapter 1 (50-1 et seq.) of Title 50 of the Code of Virginia.]~~

"Provider" means any person, entity or organization, excluding an agency of the federal government by whatever name or designation, that provides services to individuals with mental illness, mental retardation or substance addiction or abuse including the detoxification, treatment or rehabilitation of drug

addicts through the use of the controlled drug methadone or other opioid replacements. Such person, entity or organization shall include a hospital as defined in § 32.1-123 of the Code of Virginia, community services board as defined in § 37.1-194.1 of the Code of Virginia, behavioral health authority as defined in § 37.1-243 of the Code of Virginia, private provider, and any other similar or related person, entity or organization. It shall not include any individual practitioner who holds a license issued by a health regulatory board of the Department of Health Professions or who is exempt from licensing pursuant to §§ 54.1-2901, 54.1-3001, 54.1-3501, 54.1-3601 and 54.1-3701 of the Code of Virginia. It does not include any person providing uncompensated services to a family member.

"Psychosocial rehabilitation service" means care or treatment for individuals with long-term, severe psychiatric disabilities, which is designed to improve their quality of life by assisting them to assume responsibility over their lives and to function as actively and independently in society as possible, through the strengthening of individual skills and the development of environmental supports necessary to sustain community living. Psychosocial rehabilitation includes skills training, peer support, vocational rehabilitation, and community resource development oriented toward empowerment, recovery, and competency.

"Qualified Mental Health Professional (QMHP)" means a clinician in the health professions who is trained and experienced in providing psychiatric or mental health services to individuals who have a psychiatric diagnosis; including a (i) physician: a doctor of medicine or osteopathy; (ii) psychiatrist: a doctor of medicine or osteopathy, specializing in psychiatry and licensed in Virginia; (iii) psychologist: an individual with a master's degree in psychology from ~~[an a]~~ college or university with at least one year of clinical experience; (iv) social worker: an individual with at least a bachelor's degree in human services or related field (social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, human services counseling or other degree deemed equivalent to those described) from an accredited college and with at least one year of clinical experience providing direct services to persons with a diagnosis of mental illness; (v) Registered Psychiatric Rehabilitation Provider (RPRP) registered with the International Association of Psychosocial Rehabilitation Services (IAPSRs); ~~[or]~~ (vi) registered nurse licensed in the Commonwealth of Virginia with at least one year of clinical experience ~~[; or]~~ (vii) any other licensed mental health professional].

"Qualified Mental Retardation Professional (QMRP)" means an individual possessing at least one year of documented experience working directly with individuals who have mental retardation or other developmental disabilities and is one of the following: a doctor of medicine or osteopathy, a registered nurse, or holds at least a bachelor's degree in a human services field including, but not limited to, sociology, social work, special education, rehabilitation counseling, and psychology.

"Qualified Paraprofessional in Mental Health (QPPMH)" means an individual who must, at a minimum, meet one of the following criteria: (i) registered with the International Association of Psychosocial Rehabilitation Services (IAPSRs)

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as an Associate Psychiatric Rehabilitation Provider (APRP); (ii) an Associate's Degree in a related field (social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, human services counseling) and at least one year of experience providing direct services to persons with a diagnosis of mental illness; or (iii) a minimum of 90 hours classroom training and 12 weeks of experience under the direct personal supervision of a QMHP providing services to persons with mental illness and at least one year of experience (including the 12 weeks of supervised experience).

"Referral" means the process of directing an applicant or an individual to a provider or service that is designed to provide the assistance needed.

"Residential crisis stabilization service" means providing short-term, intensive treatment to individuals who require multidisciplinary treatment in order to stabilize acute psychiatric symptoms and prevent admission to a psychiatric inpatient unit.

"Residential service" means a [~~type~~ category] of service providing 24-hour care in conjunction with care and treatment or a training program in a setting other than a hospital. Residential services provide a range of living arrangements from highly structured and intensively supervised to relatively independent requiring a modest amount of staff support and monitoring. Residential services include, but are not limited to: residential treatment, group homes, supervised living, residential crisis stabilization, community gero-psychiatric residential, community intermediate care facility-MR, sponsored residential homes, medical and social [~~detox~~ detoxification], [~~sobering-up~~] and substance abuse residential treatment for women and children.

"Residential treatment service" means providing an intensive and highly structured mental health or substance abuse treatment service in a residential setting, other than an inpatient service.

"Respite care service" means providing [~~or arranging~~] for a short-term, time limited period of care of an individual for the purpose of providing relief to the individual's family, guardian, or regular care giver. Individuals providing respite care are recruited, trained, and supervised by a licensed provider. These services may be provided in a variety of settings including residential, day support, in-home, or in a sponsored residential home.

"Restraint" means the use of an approved mechanical device, physical intervention or hands-on hold, or pharmacologic agent to involuntarily prevent an individual receiving services from moving his body to engage in a behavior that places him or others at risk. This term includes restraints used for behavioral, medical, or protective purposes.

1. A restraint used for "behavioral" purposes means the use of an approved physical hold, a psychotropic medication, or a mechanical device that is used for the purpose of controlling behavior or involuntarily restricting the freedom of movement of the individual in an instance in which there is an imminent risk of an individual harming himself or others, including staff; when nonphysical interventions are

not viable; and safety issues require an immediate response.

2. A restraint used for "medical" purposes means the use of an approved mechanical or physical hold to limit the mobility of the individual for medical, diagnostic, or surgical purposes and the related post-procedure care processes, when the use of such a device is not a standard practice for the individual's condition.

3. A restraint used for "protective" purposes means the use of a mechanical device to compensate for a physical deficit, when the individual does not have the option to remove the device. The device may limit an individual's movement and prevent possible harm to the individual (e.g., bed rail or gerichair) or it may create a passive barrier to protect the individual (e.g., helmet).

4. A "mechanical restraint" means the use of an approved mechanical device that involuntarily restricts the freedom of movement or voluntary functioning of a limb or a portion of a person's body as a means to control his physical activities, and the individual receiving services does not have the ability to remove the device.

5. A "pharmacological restraint" means a drug that is given involuntarily for the emergency control of behavior when it is not standard treatment for the individual's medical or psychiatric condition.

6. A "physical restraint" (also referred to "manual hold") means the use of approved physical interventions or "hands-on" holds to prevent an individual from moving his body to engage in a behavior that places him or others at risk of physical harm. Physical restraint does not include the use of "hands-on" approaches that occur for extremely brief periods of time and never exceed more than a few seconds duration and are used for the following purposes: (i) to intervene in or redirect a potentially dangerous encounter in which the individual may voluntarily move away from the situation or hands-on approach or (ii) to quickly de-escalate a dangerous situation that could cause harm to the individual or others.

"Restriction" means anything that limits or prevents an individual from freely exercising his rights and privileges.

"Screening" means the preliminary assessment of an individual's appropriateness for admission or readmission to a service.

"Seclusion" means the involuntary placement of an individual receiving services alone, in a locked room or secured area from which he is physically prevented from leaving.

"Serious injury" means any injury resulting in bodily hurt, damage, harm or loss that requires medical attention by a licensed physician.

"Service" or "services" means individually planned interventions intended to reduce or ameliorate mental illness, mental retardation or substance addiction or abuse through care and treatment, training, habilitation or other supports that are delivered by a provider to individuals with mental illness, mental retardation, or substance addiction or abuse.

"Shall" means an obligation to act is imposed.

"Shall not" means an obligation not to act is imposed.

"Skills training" means systematic skill building through curriculum-based psychoeducational and cognitive-behavioral interventions. These interventions break down complex objectives for role performance into simpler components, including basic cognitive skills such as attention, to facilitate learning and competency.

~~["Sobering-up service" means a residential service for the diversion of public inebriates from jail for the purpose of monitoring withdrawal from excessive use of alcohol.]~~

"Social detoxification service" means providing nonmedical supervised care for the natural process of withdrawal from excessive use of alcohol or other drugs.

"Sponsored residential home" means a service where providers arrange for, supervise and provide programmatic, financial, and service support to families or individuals (sponsors) providing care or treatment in their own homes.

"State authority" means the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services. This is the agency designated by the Governor to exercise the responsibility and authority for governing the treatment of opiate addiction with an opioid drug.

"Substance abuse" means the use, without compelling medical reason, of ~~[any substance alcohol and other drugs]~~ which results in psychological or physiological dependency or danger to self or others as a function of continued use in such a manner as to induce mental, emotional or physical impairment and cause socially dysfunctional or socially disordering behavior ~~[(§ 37.1-203 of the Code of Virginia)]~~.

"Substance abuse residential treatment for women with children service" means a 24-hour residential service providing an intensive and highly structured substance abuse service for women with children who live in the same facility.

"Supervised living residential service" means the provision of significant direct supervision ~~[up to 24 hours a day and community support services in an apartment or other residential setting]~~ and community support services to individuals living in apartments or other residential settings. These services differ from supportive in-home service because the provider assumes responsibility for management of the physical environment of the residence, and staff supervision and monitoring are daily and available on a 24-hour basis. Services ~~[would be]~~ are provided based on the needs of the individual in areas such as food preparation, housekeeping, medication administration, personal hygiene, and budgeting.

"Supportive ~~[residential]~~ in-home service" ~~[(formerly supportive residential)]~~ means the provision of community support services and other structured services to assist individuals. Services strengthen individual skills and provide environmental supports necessary to attain and sustain independent community residential living. They include, but are not limited to, drop-in or friendly-visitor support and counseling to more intensive support, monitoring, training, in-home support, ~~[in-home]~~ respite care and family support

services. Services are based on the needs of the individual and include training and assistance. These services normally do not involve overnight care by the provider; however, due to the flexible nature of these services, overnight care may be provided on an occasional basis.

"Time out" means assisting an individual to regain emotional control by removing the individual from his immediate environment to a different, open location until he is calm or the problem behavior has subsided.

"Volunteer" means a person who, without financial remuneration, provides services to individuals on behalf of the provider.

PART II. LICENSING PROCESS.

12 VAC 35-105-30. Licenses.

A. Licenses are issued to providers who offer services to one or a combination of the three disability groups: persons with mental illness, persons with mental retardation, and persons with substance addiction or abuse problems.

B. Providers shall be licensed to provide specific services as defined in this chapter or as determined by the commissioner. These services include:

1. Case management;
2. Clubhouse;
3. Community gero-psychiatric residential;
4. Community intermediate care facility-MR;
- ~~[5. Day support;]~~
- ~~[5. 6.]~~ Day treatment;
- ~~[6. Emergency;]~~
7. Group home residential;
8. Inpatient psychiatric;
9. Intensive Community Treatment (ICT);
10. Intensive in-home;
11. Intensive outpatient;
12. Medical ~~[detox]~~ detoxification;
13. Mental health community support ~~[service]~~;
- ~~[14. Mental retardation day support;]~~
- ~~[15. 14.]~~ Opioid treatment;
- ~~[16. 15.]~~ Outpatient;
- ~~[17. 16.]~~ Partial hospitalization;
- ~~[18. 17.]~~ Program of assertive community treatment (PACT);
- ~~[19. 18.]~~ Psychosocial rehabilitation;
- ~~[20. 19.]~~ Residential crisis stabilization;
- ~~[21. 20.]~~ Residential treatment;

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[~~22.~~ 21.] Respite;

[~~23.~~ Sobering up;]

[~~24.~~ 22.] Social [~~detox~~ detoxification];

[~~25.~~ 23.] Sponsored residential home;

[~~26.~~ 24.] Substance abuse residential treatment for women with children;

[~~27.~~ 25.] Supervised living; and

[~~28.~~ 26.] Supportive [~~residential~~ in-home].

C. A license addendum describes the services licensed, the population served, specific locations where services are provided or organized and the terms, and conditions for each service offered by a licensed provider. For residential and inpatient services, the license identifies the number of beds each location may serve.

12 VAC 35-105-40. Application requirements.

A. All providers that are not currently licensed shall be required to apply for a license using application designated by the commissioner. Providers applying for a license must submit:

1. A working budget showing projected revenue and expenses for the first year of operation, including a revenue plan.

2. Documentation of working capital:

a. Funds or a line of credit sufficient to cover at least 90 days of operating expenses if the provider is a corporation, unincorporated organization or association, a sole proprietor or a partnership.

b. Appropriated revenue if the provider is a state or local government agency, board or commission.

3. Documentation of authority to conduct business in the Commonwealth of Virginia.

B. [~~New or existing~~] Providers must submit an application [~~for listing~~] each service [to be provided] and submit [the following items for each service]:

1. A staffing plan;

2. Employee credentials or job descriptions containing all the elements outlined in 12 VAC 35-105-410 A;

3. A service description containing all the elements outlined in 12 VAC 35-105-580 C;

4. Records management policy containing all the elements outlined in 12 VAC 35-105-390 and 12 VAC 35-105-870 A; and

5. A certificate of occupancy, floor plan (with dimensions), and any required inspections for all service locations.

C. [~~A completed application for renewal shall be submitted prior to the expiration of any full (including annual or triennial) or provisional license.~~ The provider shall confirm intent to renew the license prior to the expiration of the license and notify the department in advance of any changes in service or location.]

12 VAC 35-105-50. Issuance of licenses.

A. The commissioner issues licenses.

B. A conditional license shall be issued to a new provider or service that demonstrates compliance with administrative and policy regulations but has not demonstrated compliance with all the regulations.

1. A conditional license shall not exceed six months.

2. A conditional license may be renewed if the provider is not able to demonstrate compliance with all the regulations at the end of the license period. A conditional license and any renewals shall not exceed 12 successive months for all conditional licenses and renewals combined.

3. A provider or service holding a conditional license shall demonstrate progress toward compliance.

C. A provisional license may be issued to a provider or service that has demonstrated an inability to maintain compliance with regulations, has [~~a serious violation~~ violations] of human rights or licensing regulations [that pose a threat to the health or safety of individuals being served], has multiple violations of human rights or licensing regulations, or has failed to comply with a previous corrective action plan.

1. A provisional license may be issued at any time.

2. The term of a provisional license may not exceed six months.

3. A provisional license may be renewed; but a provisional license and any renewals shall not exceed 12 successive months for all provisional licenses and renewals combined.

4. A provider or service holding a provisional license shall demonstrate progress toward compliance.

5. A provisional license for a service shall be noted as a stipulation on the provider license. The stipulation shall also indicate the violations to be corrected and the expiration date of the provisional license.

D. A full license shall be issued after a provider or service demonstrates compliance with all the applicable regulations.

1. A full license may be granted for up to three years. The length of the license shall be in the sole discretion of the commissioner.

2. If a full license is granted for three years, it shall be referred to as a triennial license. A triennial license shall be granted to providers who have had no noncompliances or only [~~minor~~] violations [that did not pose a threat to the health or safety of individuals being served] during the previous license period. The commissioner may waive this limitation if the provider has demonstrated consistent compliance for more than a year or that sufficient provider oversight is in place.

3. If a full license is granted for one year, it shall be referred to as an annual license.

4. The term of the first full renewal license after the expiration of a conditional or provisional license may not exceed one year.

E. The license may bear stipulations. Stipulations may be limitations on the provider or may impose additional requirements. Terms of any such stipulations on licenses issued to the provider shall be specified on the provider license.

F. A license shall not be transferred or assigned to another provider. A new application shall be made and a new license issued when there is a change in ownership.

G. A license shall not be issued or renewed unless the provider is affiliated with a local human rights committee.

H. No service may be issued a license with an expiration date after the expiration date of the provider license.

I. A license continues in effect after the expiration date if the provider has submitted a renewal application before the date of expiration and there are no grounds to deny the application.

12 VAC 35-105-60. Modification.

A. Upon written request by the provider, the license may be modified during the term of the license with respect to the populations served (disability, age, and gender), the services offered, the locations where services are provided, stipulations and the maximum number of beds. Approval of such request shall be at the sole discretion of the commissioner.

B. A change requiring a modification of the license shall not be implemented prior to approval by the commissioner. The department may give approval to implement a modification pending the issuance of the modified license based on guidelines determined by the commissioner.

12 VAC 35-105-70. Onsite reviews.

A. The department shall conduct an announced or unannounced onsite review of all new providers and services to determine compliance with [~~these regulations~~ this chapter].

B. The department shall conduct unannounced onsite reviews of licensed providers and each of its services at any time and at least annually to determine compliance with these regulations. The annual unannounced onsite reviews shall be focused on preventing specific risks to individuals, including an evaluation of the physical facilities in which the services are provided.

C. The department may conduct announced and unannounced onsite reviews at any time as part of the investigations of complaints or incidents to determine if there is a violation of [~~these regulations~~ this chapter].

12 VAC 35-105-80. Complaint investigations.

The department shall investigate all complaints regarding potential violations of licensing regulations. Complaint investigations may be based on onsite reviews, a review of records, a review of provider reports or telephone interviews.

12 VAC 35-105-90. Compliance.

A. The department shall determine the level of compliance with each regulation as follows:

1. "Compliance" (C) means the provider is clearly in compliance with a regulation.

2. "Noncompliance" (NC) means the provider is clearly in noncompliance with part or all of a regulation.

3. "Not Determined" (ND) means that the provider must provide additional information to determine compliance with a regulation.

4. "Not Applicable" (NA) means the provider is not required to demonstrate compliance with the provisions of a regulation at the time.

B. The provider, including its employees, contract service providers, student interns and volunteers, shall comply with all applicable regulations.

12 VAC 35-105-100. Sanctions.

A. The commissioner may invoke the sanctions enumerated in § 37.1-185.1 of the Code of Virginia upon receipt of information that a licensed provider is:

1. In violation of the provisions of §§ 37.1-84.1 and 37.1-179 through 37.1-189.1 of the Code of Virginia, these regulations, or the provisions of the Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers of Mental Health, Mental Retardation and Substance Abuse Services (12 VAC 35-115); and

2. Such violation adversely impacts the human rights of individuals, or poses an imminent and substantial threat to the health, safety or welfare of individuals.

The commissioner shall notify the provider in writing of the specific violations found, and of his intention to convene an informal conference pursuant to § 2.2-4019 of the Code of Virginia at which the presiding officer will be asked to recommend issuance of a special order.

B. The sanctions contained in the special order shall remain in effect during the pendency of any appeal of the special order.

12 VAC 35-105-110. Denial, revocation or suspension of a license.

A. An application for a license or license renewal may be denied and a full, conditional, or provisional license may be revoked or suspended for one or more of the following reasons:

1. The provider has violated any provisions of Chapter 8 (§ 37.1-179 et seq.) of Title 37.1 of the Code of Virginia or these licensing regulations;

2. The provider's conduct or practices are detrimental to the welfare of any individual or in violation of human rights identified in § 37.1-84.1 of the Code of Virginia or the human rights regulations (12 VAC 35-115);

3. The provider permits, aids, or abets the commission of an illegal act;

4. The provider fails or refuses to submit reports or to make records available as requested by the department;

5. The provider refuses to admit a representative of the department to the premises; or

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6. The provider fails to submit an adequate corrective action plan.

B. A provider shall be notified in writing of the department's intent to deny, revoke or suspend a License; the reasons for the action; the right to appeal; and the appeal process. The provider has the right to appeal the department's decision under the provisions of the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia).

12 VAC 35-105-120. Variances.

The commissioner may grant a variance to a specific regulation if he determines that such a variance will not jeopardize the health, safety or welfare of individuals and upon demonstration by the provider requesting such variance that complying with the regulation would be a hardship unique to the provider. A provider shall submit a request for a variance in writing to the commissioner. A variance may be time limited or have other conditions attached to it. The department must approve a variance prior to implementation.

12 VAC 35-105-130. Confidentiality of records.

Records that are confidential under federal or state law shall be maintained as confidential by the department and shall not be further disclosed except as permitted by law.

PART III. ADMINISTRATIVE SERVICES.

Article 1. Management and Administration.

12 VAC 35-105-140. License availability.

The current license or a copy shall be prominently displayed for public inspection in all locations.

12 VAC 35-105-150. Compliance with applicable laws, regulations and policies.

The provider including its employees, contractors, students, and volunteers shall comply with:

1. These regulations;
2. Terms of the license;
3. All applicable federal, state or local laws, and regulations including but not limited to:
 - a. Laws regarding employment practices including Equal Employment Opportunity Act;
 - b. Americans with Disabilities Act;
 - c. Occupational Safety and Health Administration regulations;
 - d. Virginia Department of Health regulations;
 - e. Laws or regulations of the Department of Health Professions;
 - f. Uniform Statewide Building Code; and
 - g. Uniform Statewide Fire Prevention Code.

4. Section 37.1-84.1 of the Code of Virginia on the human rights of individuals receiving services and related human rights regulations;

5. Section 37.1-197.1 of the Code of Virginia regarding prescreening and predischarge planning. Providers responsible for complying with § 37.1-197.1 are required to develop and implement policies and procedures that include:

a. Identification of employees or services responsible for prescreening and predischarge planning services for all disability groups; and

b. Completion of predischarge plans prior to an individual's discharge in consultation with the state facility which:

(1) Involve the individual or his legally authorized representative and reflect the individual's preferences to the greatest extent possible consistent with the individual's needs.

(2) Include the mental health, mental retardation, substance abuse, social, educational, medical, employment, housing, legal, advocacy, transportation, and other services that the individual will need upon discharge into the community and identify the public or private agencies or persons that have agreed to provide them.

6. The provider's own policies.

12 VAC 35-105-160. Reviews by the department; requests for information.

A. The provider shall permit representatives from the department to conduct reviews to:

1. Verify application information;
2. Assure compliance with [~~these regulations~~ this chapter]; and
3. Investigate complaints.

B. The provider shall cooperate fully with inspections and provide all information requested to assist representatives from the department who conduct inspections.

C. The provider shall collect, maintain and report:

1. Each allegation of abuse or neglect to the assigned human rights advocate within 24 hours from the receipt of the initial allegation and the investigating authority shall provide a written report of the results of the investigation of abuse or neglect to the provider and the human rights advocate within 10 working days, unless an exemption has been granted, from the date the investigation began. The report shall include but not be limited to the following: whether abuse, neglect or exploitation occurred; type of abuse; and whether the act resulted in physical or psychological injury.

2. Deaths and serious injuries in writing to the department within 24 hours of discovery and by phone to the legally authorized representative as applicable within 24 hours to include but not be limited to the following: the date and

place of death or serious injury; nature of injuries and treatment required; and circumstances of death or serious injury.

3. Each instance of seclusion or restraint that does not comply with the human rights regulations or approved variances, or that results in injury to an individual, shall be reported to the legally authorized representative and the assigned human rights advocate within 24 hours.

D. The provider shall submit, or make available, reports and information that the department requires to establish compliance with these regulations and applicable statutes.

E. Records that are confidential under federal or state law shall be maintained as confidential by the department and shall not be further disclosed except as permitted by law; however, there shall be no right of access to communications that are privileged pursuant to § 8.01-581.17 of the Code of Virginia.

F. If compliance with a regulation cannot be determined, the department shall issue a licensing report requesting additional information. Additional information must be submitted within 10 business days of the issuance of the licensing report. Extensions may be granted by the department when requested prior to the due date, but extensions shall not exceed an additional 10 business days.

12 VAC 35-105-170. Corrective action plan.

A. If there is noncompliance with any of these regulations during an initial or ongoing review or investigation, the department shall issue a licensing report describing the noncompliance and requesting the provider to submit a corrective action plan.

B. The provider shall submit to the department and implement a written corrective action plan for each regulation found to be in noncompliance with these regulations identified on the licensing report.

C. The [~~plan~~] corrective action plan shall include a:

1. Description of the corrective actions to be taken;
2. Date of completion for each action; and
3. Signature of the person responsible for the service.

D. The provider shall submit corrective action plans to the department within [~~40~~ 15] business days of the issuance of the licensing report. Extensions may be granted by the department when requested prior to the due date, but extensions shall not exceed an additional 10 business days. An immediate corrective action shall be required if the department determines that the violations pose a danger to individuals.

E. A corrective action plan shall be approved by the department. The provider has an additional 10 business days to submit a revised corrective action plan after receiving a notice that the plan submitted has not been approved.

F. The provider shall monitor implementation of pledged corrective action and include a plan for such monitoring in its quality assurance activities specified in 12 VAC 30-105-620.

12 VAC 35-105-180. Notification of changes.

A. The provider shall notify the department in writing prior to implementing changes that affect:

1. Organizational or administrative structure, including the name of the provider;
2. Geographic location of the provider or its services;
3. Service description as defined in these regulations;
4. Significant changes in [~~employee or contractor~~] qualifications [required for a position or qualifications of an individual occupying a position]; or
5. Bed capacity for services providing residential or inpatient services.

B. The provider shall not implement the specified changes without the approval of the department.

C. The provider shall provide any documentation necessary for the department to determine continued compliance with these regulations after any of these specified changes are implemented.

[D. A provider shall notify the department in writing of its intent to discontinue services 30 days prior to the cessation of services. The provider will continue to provide all services that are identified in every individual's Individualized Services Plan (ISP) after it has given official notice of its intent to cease operations and until each individual is appropriately discharged. The provider will further continue to maintain substantial compliance with all applicable regulations as it discontinues its services.

E. All individuals receiving services shall be notified of the provider's intent to cease services in writing 30 days prior to the cessation of services. This written notification will be documented in each individual's ISP. Also, refer to Records Management, Part V (12 VAC 35-105-870 et seq.) of this chapter.]

12 VAC 35-105-190. Operating authority, governing body and organizational structure.

A. The provider shall provide evidence of its operating authority.

1. A public organization shall provide documents describing the administrative framework of the governmental department of which it is a component.
2. All private organizations except sole proprietorships shall provide a certification from the State Corporation Commission.

B. The provider's governing body and organizational structure shall be clearly identified by providing an organizational chart.

C. The provider shall document the role and actions of the governing body, which shall be consistent with its operating authority. The provider shall identify its operating elements and services, the internal relationship among these elements and services, and the management or leadership structure.

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12 VAC 35-105-200. Appointment of administrator.

The provider shall appoint qualified persons to whom it delegates, in writing, the authority and responsibility for the administrative direction and day-to-day operation of the provider and its services.

12 VAC 35-105-210. Fiscal accountability.

A. The provider shall document financial resources to operate its services or facilities or shall have a line of credit sufficient to cover 90 days of operating expense, based on a working budget showing projected revenue and expenses.

B. At the end of each fiscal year, the provider shall prepare, according to generally accepted accounting principles (GAAP) or those standards promulgated by the Governmental Accounting Standards Board (GASB) and the State Auditor of Public Accounts:

1. An operating statement showing revenue and expenses for the fiscal year just ended.
2. A balance sheet showing assets and liabilities for the fiscal year just ended. At least once every three years, all financial records shall be audited by an independent Certified Public Accountant (CPA) or audited as otherwise provided by law. [Providers operating as a part of a local government agency are excluded from providing a balance sheet; however, they shall provide a financial statement.]

C. The provider shall have written internal controls to minimize the risk of theft or embezzlement of provider funds.

D. At a minimum, the person who has the authority and responsibility for the fiscal management of the provider shall be bonded or otherwise indemnified.

12 VAC 35-105-220. Indemnity coverage.

To protect the interests of individuals, employees, and the provider from risks of liability, there shall be indemnity coverage to include:

1. General liability;
2. Professional liability;
3. Vehicular liability; and
4. Property damage.

12 VAC 35-105-230. Written fee schedule.

If the provider charges for services, the written schedule of rates and charges shall be available upon request.

12 VAC 35-105-240. Policy on funds of individuals receiving services.

A. The provider shall establish and implement a written policy for handling funds of individuals receiving services, including providing for separate accounting of individual funds.

B. The provider shall have documented financial controls to minimize the risk of theft or embezzlement of funds of individuals receiving services.

C. The provider shall purchase a surety bond or otherwise provide assurance for the security of all funds of individuals receiving services deposited with the provider.

12 VAC 35-105-250. Deceptive or false advertising.

A. The provider shall not use any advertising that contains false, misleading or deceptive statements or claims, or false or misleading disclosure of fees and payment for services.

B. The provider's name and service names shall not imply the provider is offering services for which it is not licensed.

Article 2.

Physical Environment.

12 VAC 35-105-260. Building inspection and classification.

All locations shall be inspected and approved as required by the appropriate building regulatory entity. Approval shall be a Certificate of Use and Occupancy indicating the building is classified for its proposed licensed purpose. This section does not apply to correctional facilities or home and noncenter-based services. Sponsored residential services shall certify compliance of sponsored residential homes with this regulation.

12 VAC 35-105-270. Building modifications.

A. Building plans and specifications for new construction of locations, change in use of existing locations, and any structural modifications or additions to existing locations where services are provided shall be submitted for review by the department [~~and shall be approved by appropriate regulatory authorities~~ to determine compliance with the licensing regulations]. This section does not apply to correctional facilities, jails, or home and noncenter-based services.

B. An interim plan addressing safety and continued service delivery shall be required for new construction or for conversion, structural modifications or additions to existing buildings.

12 VAC 35-105-280. Physical environment.

A. The physical environment shall be appropriate to the population served and the services provided.

B. The physical environment and furnishings shall be clean, dry, free of foul odors, safe, and well-maintained.

C. The [physical environment,] design, structure, furnishing, and lighting shall [~~promote the ability of employees and individuals to have clear visual perception of the physical environment~~] be appropriate to the population served and the services provided].

D. Floor surfaces and floor covering shall promote mobility in areas used by individuals and shall promote maintenance of sanitary conditions.

E. The physical environment shall be well ventilated. Temperatures shall be maintained between 65°F and 80°F.

F. Adequate hot and cold running water of a safe and appropriate temperature shall be available. Hot water accessible to [~~residents~~ individuals being served] shall be

maintained within a range of 100-120°F. [If temperatures cannot be maintained within the specified range, the provider shall make provisions for protecting individuals from injury due to scalding.]

G. Lighting shall be sufficient for the activities being performed and all areas within buildings and outside entrances and parking areas shall be lighted for safety.

H. Recycling, composting, and garbage disposal shall not create a nuisance, permit transmission of disease, or create a breeding place for insects or rodents.

I. If smoking is permitted, the provider shall make provisions for alternate smoking areas separate from the service environment. This regulation does not apply to home-based services.

J. For all program areas added after [~~the effective date of these regulations~~ September 19, 2002], minimum room height shall be 7-1/2 feet.

K. This section does not apply to home and noncenter-based services. Sponsored residential services shall certify compliance of sponsored residential homes with this regulation.

12 VAC 35-105-290. Food service inspections.

Any location where the provider is responsible for preparing or serving food shall request inspection and approval by state or local health authorities regarding food service and general sanitation at the time of the original application and annually thereafter. Documentation of the most recent three inspections and approval shall be kept on file. [This does not apply to sponsored residential services.]

12 VAC 35-105-300. Sewer and water inspections.

[A.] A location shall either be on [~~city or county~~ public] water and sewage systems or the location's water and sewage system shall be inspected and approved by state or local health authorities at the time of its original application and annually thereafter. Documentation of the three most recent inspections and approval shall be kept on file. Sponsored residential home services shall certify compliance of sponsored residential homes with this regulation.

[B. A location that is not on a public water system shall have a water sample tested annually by an accredited, independent laboratory for the absence of chloroform. The water sample shall also be tested for lead or nitrates if recommended by the local health department. Documentation of the three most recent inspections shall be kept on file.]

12 VAC 35-105-310. Weapons.

[~~To the extent permitted by law, weapons shall be prohibited, except when carried by licensed security personnel. Sponsored residential home services shall certify compliance of sponsored residential homes with this regulation. This section does not apply to correctional facilities or to individuals, family members or friends of individuals receiving services in their own home. The facility shall have and implement a written policy governing the use and possession of firearms, pellet guns, air rifles and other weapons on the facility's premises. The policy shall provide that no firearms,~~

pellet guns, air rifles and other weapons on the facility's premises shall be permitted unless the weapons are:

- 1. In the possession of licensed security or sworn law-enforcement personnel;*
- 2. Kept securely under lock and key; or*
- 3. Used under the supervision of a responsible adult in accordance with policies and procedures developed by the facility for the weapons' lawful and safe use.]*

12 VAC 35-105-320. Fire inspections.

The provider shall document at the time of its original application and annually thereafter that buildings and equipment in locations with more than eight beds are maintained in accordance with the Virginia Statewide Fire Prevention Code (13 VAC 5-51). This section does not apply to correctional facilities or home and noncenter-based or sponsored residential home services.

*Article 3.
Physical Environment of Residential/Inpatient Service
Locations.*

12 VAC 35-105-330. Beds.

A. The provider shall not operate more beds than the number for which its service location or locations are licensed.

B. A community intermediate care facility for the mentally retarded may not have more than 20 beds at any one location. This applies to new applications for services after [~~the effective date of these regulations~~ September 19, 2002].

12 VAC 35-105-340. Bedrooms.

A. Size of bedrooms.

- 1. Single occupancy bedrooms shall have no less than 80 square feet of floor space.*
- 2. Multiple occupancy bedrooms shall have no less than 60 square feet of floor space per individual.*
- 3. This subsection does not apply to community geropsychiatric residential services.*

B. No more than four individuals shall share a bedroom.

C. Each individual shall be assigned adequate storage space accessible to the bedroom for clothing and personal belongings.

D. This section does not apply to correctional facilities [; and] jails [~~and sobering-up centers~~]. Sponsored residential home services shall certify compliance of sponsored residential homes with this regulation.

12 VAC 35-105-350. Condition of beds.

Beds shall be clean, comfortable and equipped with a mattress, pillow, blankets, and bed linens. [~~Bed linens shall be changed every seven days or more often as needed. Providers shall give individuals a partial bath, clean clothing, and linens each time their clothing or bed linen is soiled. When a bed is soiled, providers shall assist individuals with bathing as needed, and provide clean clothing and bed linen.~~]

Final Regulations

Sponsored residential home services shall certify compliance of sponsored residential homes with this regulation.

12 VAC 35-105-360. Privacy.

A. Bedroom and bathroom windows and doors shall provide privacy.

B. Bathrooms not intended for individual use shall provide privacy for showers and toilets.

C. No required path of travel to the bathroom shall be through another bedroom.

D. This section does not apply to correctional facilities and jails. Sponsored residential home services shall certify compliance of sponsored residential homes with this regulation.

12 VAC 35-105-370. Ratios of toilets, basins and showers or baths.

For all residential and inpatient locations established, constructed or reconstructed after January 13, 1995, there shall be at least one toilet, one hand basin, and shower or bath for every four individuals. Sponsored residential home services shall certify compliance of sponsored residential homes with this regulation. This section does not apply to correctional facilities or jails.

12 VAC 35-105-380. Lighting.

Each location shall have adequate lighting in halls and bathrooms at night. Sponsored residential home services shall certify compliance of sponsored residential homes with this regulation.

Article 4. Human Resources.

12 VAC 35-105-390. Confidentiality and security of personnel records.

A. The provider shall maintain an organized system to manage and protect the confidentiality of personnel files and records.

B. Physical and data security controls shall exist for electronic records.

C. Providers shall comply with requirements of the American with Disabilities Act regarding retention of employee health-related information in a file separate from personnel files.

12 VAC 35-105-400. Criminal [~~background checks~~ registry checks].

~~[A. After July 1, 1999, providers shall not hire as employees or contractors in any direct care position persons who have been convicted of crimes outlined in § 37.1-183.3 of the Code of Virginia.~~

~~1. Prior to a new employee or contractor beginning duties, the provider shall obtain a disclosure statement concerning whether he has ever been convicted of or is the subject of pending charges for any offense and the provider shall submit all information required by the department to complete the background checks.~~

~~2. The provider shall maintain the following documentation in the employee or contractor's confidential personnel record:~~

~~a. The employee's disclosure statement;~~

~~b. Documentation that the provider submitted all information required by the department to complete the background checks or memoranda from the department transmitting the results to the provider.~~

~~B. Prior to a new employee or contractor beginning duties, the provider shall obtain the employee's or contractor's written consent and personal information necessary to obtain a search of the registry of founded complaints of child abuse and neglect maintained by the Department of Social Services. Results of the search of the registry shall be maintained in the employee's or contractor's personnel record.~~

A. The provider shall develop a policy for the criminal history and registry checks for all employees, contractors, students and volunteers. The policy shall contain, at a minimum, a disclosure statement concerning whether the person has ever been convicted of or is the subject of pending charges for any offense.

B. After July 1, 1999, providers shall comply with the background check requirements for direct care positions outlined in § 37.1-183.3 of the Code of Virginia.

C. The provider shall submit all information required by the department to complete the background checks for all employees, and for contractors, students and volunteers, if required by the provider's policy.

D. Prior to a new employee beginning his duties, the provider shall obtain the employee's written consent and personal information necessary to obtain a search of the registry of founded complaints of child abuse and neglect maintained by the Department of Social Services. Results of the search of the registry shall be maintained in the employee's personnel record.

E. The provider shall maintain the following documentation:

1. The disclosure statement; and

2. Documentation that the provider submitted all information required by the department to complete the background and registry checks, and memoranda from the department transmitting the results to the provider.]

12 VAC 35-105-410. Job description.

A. Each employee or contractor shall have a written job description that includes:

1. Job title;

2. Duties and responsibilities required of the position;

3. Job title of the immediate supervisor; and

4. Minimum knowledge, skills, and abilities, experience or professional qualifications required for entry level as specified in 12 VAC 35-105-420.

B. Employees or contractors shall have access to their current job description. There shall be a mechanism for advising

employees or contractors of changes to their job responsibilities.

12 VAC 35-105-420. Qualifications of employees or contractors.

A. Any person who assumes the responsibilities of any employee position shall meet the minimum qualifications of that position as determined by job descriptions.

B. Employees and contractors shall comply, as required, with the regulations of the Department of Health Professions. The provider shall design and implement a mechanism to verify professional credentials.

C. [~~Program~~ Service] directors shall have experience in working with the population served and in providing the services outlined in the service description.

D. Job descriptions shall include minimum knowledge, skills and abilities, professional qualification and experience appropriate to the duties and responsibilities required of the position.

12 VAC 35-105-430. Employee or contractor personnel records.

A. Employee or contractor personnel record, whether hard-copy or electronic, shall include:

1. Identifying information;
2. Education and training history;
3. Employment history;
4. Results of the provider credentialing process including methods of verification of applicable professional licenses or certificates;
5. Results of reasonable efforts to secure job-related references and reasonable verification of employment history;
6. Results of criminal background checks and a search of the registry of founded complaints of child abuse and neglect, if any;
7. Results of performance evaluations;
8. A record of disciplinary action taken by the provider, if any;
9. A record of adverse action by any licensing bodies and organizations and state human rights regulations, if any; and
10. A record of participation in employee development activities, including orientation.

B. Each employee or contractor personnel record shall be retained in its entirety for a minimum of three years after termination of employment.

12 VAC 35-105-440. Orientation of new employees, contractors, volunteers, and students.

New employees, contractors, volunteers, and students shall be oriented commensurate with their function or job-specific responsibilities within [~~14 calendar~~ 15 business] days.

Orientation to each of the following policies shall be documented. Orientation shall include:

1. Objectives and philosophy of the provider;
2. Practices of confidentiality including access, duplication, and dissemination of any portion of an individual's record;
3. Practices that assure an individual's rights including orientation to human rights regulations;
4. Applicable personnel policies;
5. Emergency preparedness procedures;
6. Infection control practices and measures; and
7. Other policies and procedures that apply to specific positions and specific duties and responsibilities.

12 VAC 35-105-450. Employee training and development.

The provider shall provide training and development opportunities for employees to enable them to perform the responsibilities of their job. The policy must address retraining on medication administration, behavior management, and emergency preparedness. Training and development shall be documented in the employee personnel records.

12 VAC 35-105-460. Emergency medical or first aid training.

There shall be at least one employee or contractor on duty at each location who holds a current certificate, issued by a recognized authority, in standard first aid and cardiopulmonary resuscitation, or emergency medical training. A nurse or physician who holds a current professional license shall be deemed to hold a current certificate in first aid, but not in CPR.

12 VAC 35-105-470. Notification of policy changes.

All employees or contractors shall be kept informed of policy changes that affect performance of duties.

12 VAC 35-105-480. Employee or contractor performance evaluation.

A. The provider shall develop and implement a policy for evaluating employee or contractor performance.

B. Employee development needs and plans shall be a part of the performance evaluation.

C. The provider shall evaluate employee or contractor performance at least annually.

12 VAC 35-105-490. Written grievance policy.

The provider shall have a written grievance policy and a mechanism to inform employees of grievance procedures.

12 VAC 35-105-500. Students and volunteers.

A. The provider shall have and implement a written policy that clearly defines and communicates the requirements for the use and responsibilities of students and volunteers including selection and supervision.

B. The provider shall not rely on students or volunteers for the provision of direct care services. [The provider staffing plan shall not include volunteers or students.]

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12 VAC 35-105-510. Tuberculosis screening.

A. Each new employee, contractor, student or volunteer who will have direct contact with individuals being served shall obtain ~~[an evaluation a statement of certification by a qualified licensed practitioner]~~ indicating the absence of tuberculosis in a communicable form within 30 days of employment or contact with individuals. A statement ~~[signed by a qualified, licensed practitioner documenting absence of tuberculosis in a communicable form includes the types of tests administered, dates of the tests, and the results of those tests. An evaluation of certification]~~ shall not be required for an employee who has separated from service with another licensed provider with a break in service of six months or less or is currently working for another licensed provider. The employee must submit a copy of the original screening to the provider.

B. All employees, contractors, students or volunteers in substance abuse outpatient or substance abuse residential treatment services shall be certified as tuberculosis free on an annual basis ~~[by a qualified licensed practioner]~~.

C. ~~[An Any]~~ employee, contractor, student or volunteer who comes in contact with a known case of ~~[infectious active]~~ tuberculosis ~~[disease]~~ or who develops ~~[chronic respiratory]~~ symptoms ~~[of active tuberculosis disease (including, but not limited to fever, chills, hemoptysis, cough, fatigue, night sweats, weight loss or anorexia)]~~ of three weeks duration shall be screened as determined appropriate based on consultation with the local health department.

D. An employee, contractor, student or volunteer suspected of having ~~[infectious active]~~ tuberculosis shall not be permitted to return to work or have contact with employees, contractors, students, volunteers or individuals receiving services until a physician has determined that the person is free of ~~[infectious active]~~ tuberculosis.

Article 5. Health and Safety Management.

12 VAC 35-105-520. Risk management.

A. The provider shall designate a person responsible for risk management.

B. The provider shall document and implement a plan to identify, monitor, reduce and minimize risks associated with personal injury, property damage or loss and other sources of potential liability.

C. As part of the plan, the provider shall conduct and document at least annually its own safety inspections of all service locations owned, rented or leased. Recommendations for safety improvement shall be documented and implemented.

D. The provider shall document serious injuries to employees, contractors, students, volunteers and visitors. Documentation shall be kept on file for three years. The provider shall evaluate injuries at least annually. Recommendations for improvement shall be documented and implemented.

E. The risk management plan shall establish and implement policies to identify any populations at risk for falls and to develop a prevention/management program.

F. The provider shall develop, document and implement infection control measures, including the use of universal precautions.

12 VAC 35-105-530. Emergency preparedness and response plan.

A. The provider shall develop a written emergency preparedness and response plan for all of a provider's services and locations. The plan shall address:

1. Documentation of contact with the local emergency coordinator to determine local disaster risks and community-wide plans to address different disasters and emergency situations.

2. Analysis of the provider's capabilities and potential hazards, including natural disasters, severe weather, fire, flooding, work place violence or terrorism, missing persons, severe injuries, or other emergencies that would disrupt the normal course of service delivery.

3. Written emergency management policies outlining specific responsibilities for provision of administrative direction and management of response activities, coordination of logistics during the emergency, communications, life safety of employees, contractors, students, volunteers, visitors and individuals receiving services, property protection, community outreach, and recovery and restoration.

4. Written emergency response procedures for assessing the situation; protecting individuals receiving services, employees, contractors, students, volunteers, visitors, equipment and vital records; and restoring services. Emergency procedures shall address:

a. Communicating with employees, contractors and community responders;

b. Warning and notification of individuals receiving services;

c. Providing emergency access to secure areas and opening locked doors;

d. Conducting evacuations to emergency shelters or alternative sites and accounting for all individuals receiving services;

e. Relocating individuals receiving residential or inpatient services, if necessary;

f. Notifying family members and legal guardians;

g. Alerting emergency personnel and sounding alarms;

[h. Locating and shutting off utilities when necessary.]

5. Supporting documents that would be needed in an emergency, including emergency call lists, building and site maps necessary to shut off utilities, designated escape routes, and list of major resources such as local emergency shelters.

6. Schedule for testing the implementation of the plan and conducting emergency preparedness drills.

B. The provider shall develop and implement periodic emergency preparedness and response training for all employees, contractors, students and volunteers. Training shall cover responsibilities for:

1. Alerting emergency personnel and sounding alarms;
2. Implementing evacuation procedures, including evacuation of individuals with special needs (i.e., deaf, blind, nonambulatory);
3. Using, maintaining, and operating emergency equipment;
4. Accessing emergency medical information for individuals receiving services; and
5. Utilizing community support services.

C. The provider shall review the emergency preparedness plan annually and make necessary revisions. Such revisions shall be communicated to employees, contractors, students and volunteers and incorporated into training for employees, contractors, students and volunteers and orientation of individuals to services.

D. In the event of a disaster, fire, emergency or any other condition that may jeopardize the health, safety and welfare of individuals, the provider shall take appropriate action to protect the health, safety and welfare of the individuals receiving services and take appropriate actions to remedy the conditions as soon as possible.

E. Employees, contractors, students and volunteers shall be knowledgeable in and prepared to implement the emergency preparedness plan in the event of an emergency. The plan shall include a policy regarding periodic emergency preparedness training for all employees, contractors, students and volunteers.

F. In the event of a disaster, fire, emergency, or any other condition that may jeopardize the health, safety and welfare of individuals, the provider ~~[shall notify the department of the condition at the location and status of the individuals within one business day~~ should first respond and stabilize the disaster/emergency. After the disaster/emergency is stabilized, the provider should report the disaster/emergency to the department, but no later than 72 hours after the incident occurs].

G. This section does not apply to home and noncenter-based services.

12 VAC 35-105-540. Access to telephone in emergencies; emergency telephone numbers.

A. Telephones shall be accessible for emergency purposes.

B. Current emergency telephone numbers and location of the nearest hospital, ambulance service, rescue squad and other trained medical personnel, poison control center, fire station and the police are prominently posted near the telephones.

C. This section does not apply to home and noncenter-based services and correctional facilities.

12 VAC 35-105-550. First aid kit accessible.

[~~A.~~] A well-stocked first aid kit shall be maintained and readily accessible for minor injuries and medical emergencies at each service location and to employees or contractors providing in-home services or traveling with individuals. [The minimum requirements of a well-stocked first aid kit that shall be maintained include a thermometer, bandages, saline solution, band-aids, sterile gauze, tweezers, instant ice-pack, adhesive tape, first-aid cream, antiseptic soap, an accessible, unexpired 30 cc bottle of Syrup of Ipecac (for use at the direction of the Poison Control Center or a physician), and activated charcoal (for use at the direction of the Poison Control Center or a physician).]

[~~B. One unexpired container of activated charcoal and one unexpired 30 cc bottle of Syrup of Ipecac shall be available at each service location for use at the direction of the poison control center or physician and shall be kept locked when not in use.~~]

12 VAC 35-105-560. Operable flashlights or battery lanterns.

Operable flashlights or battery lanterns shall be readily accessible to employees and contractors in services that operate between dusk and dawn to use in emergencies. This section does not apply to home and noncenter-based services.

PART IV. SERVICES AND SUPPORTS.

Article 1. Service Description and Staffing.

12 VAC 35-105-570. Mission statement.

The provider shall develop a written mission statement that clearly identifies its philosophy, purpose, and goals.

12 VAC 35-105-580. Service description requirements.

A. The provider shall develop, implement, review and revise its services according to the provider's mission and shall have that information available for public review.

B. The provider shall document that each service offers a structured program of care designed to meet the individuals' physical and emotional needs; provide protection, guidance and supervision; and meet the objectives of any required service plan.

C. The provider shall prepare a written description of each service it offers. Service description elements shall include:

1. Goals;
2. Care, treatment, training, habilitation, or other supports provided;
3. Characteristics and needs of the population served;
4. Contract services, if any;
5. Admission, continued stay and exclusion criteria;
6. Termination of treatment and discharge or transition criteria; and

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7. Type and role of employees or contractors.

D. The provider shall revise a service description whenever the service description changes.

E. The provider shall not implement services that are inconsistent with its most current service description.

F. The provider shall provide for the physical separation of children and adults in residential and inpatient services and shall provide separate group programming for adults and children, except in the case of family services. The provider shall ~~[develop a plan providing provide]~~ for the safety of children accompanying parents receiving services. Older adolescents transitioning from school to adult activities may participate in mental retardation day support services with adults.

G. If the provider offers substance abuse treatment services, the service description shall address the timely and appropriate treatment of substance abusing pregnant women.

12 VAC 35-105-590. Provider staffing plan.

A. The provider shall design and implement a staffing plan including the type and role of employees and contractors that reflects the:

1. Needs of the population served;
2. Types of services offered;
3. The service description; and
4. The number of people served.

B. The provider shall develop a transition staffing plan for new services [, added locations, and changes in capacity].

C. The following staffing requirements relate to supervision.

1. The provider shall describe how employees, volunteers, contractors and student interns are to be supervised in the staffing plan.
2. Supervision of employees, volunteers, contractors and student interns shall be provided by persons who have experience in working with the population served and in providing the services outlined in the service description. In addition, supervision of mental health services shall be performed by a QMHP and supervision of mental retardation services shall be performed by a QMRP or an employee or contractor with experience equivalent to the educational requirement.
3. Supervision shall be appropriate to the services provided and the needs of the individual. Supervision shall be documented.
4. Supervision shall include responsibility for approving assessments and individualized services plans. This responsibility may be delegated to an employee or contractor who is a QMHP or QMRP or who has equivalent experience.

D. The provider shall employ or contract with persons with appropriate training [,] as necessary [,] to ~~[serve meet]~~ the [specialized] needs of [and to ensure the safety of] individuals [being served in residential services] with medical

or nursing needs, speech, language or hearing problems or other needs where specialized training is necessary.

12 VAC 35-105-600. Nutrition.

A. A provider preparing and serving food shall:

1. Have a written plan for the provision of food services, which ensures access to nourishing, well-balanced, healthful meals;
2. Make reasonable efforts to prepare meals that consider cultural background, personal preferences, and food habits and that meet the dietary needs of the individuals served; and
3. Assist individuals who require assistance feeding themselves in a manner that effectively addresses any deficits.

B. Providers of residential and inpatient services shall develop and implement a policy to monitor each individual's food consumption for:

1. Warning signs of changes in physical or mental status related to nutrition; and
2. Compliance with any needs determined by the individualized services plan or prescribed by a physician, nutritionist or health care professional.

12 VAC 35-105-610. Community participation.

Opportunities shall be provided for individuals receiving services to participate in community activities. This regulation ~~[does not apply to outpatient, inpatient and sobering-up services]~~ applies to residential, day support and day treatment services].

12 VAC 35-105-620. Monitoring and evaluating service quality.

The provider shall have a mechanism to monitor and evaluate service quality and effectiveness on a systematic and ongoing basis. The provider shall implement improvements, when indicated.

Article 2.

Screening, Admission, Assessment, Service Planning and Orientation.

12 VAC 35-105-630. Policies on screening, admission and referrals.

A. The provider shall establish written criteria for admission that include:

1. A description of the population to be served;
2. A description of the types of services offered; and
3. Exclusion criteria.

B. The provider shall admit only those individuals whose service needs are consistent with the service description, for whom services are available, and for which staffing levels and types meet the needs of the individuals served.

C. The provider shall complete a preliminary assessment detailed enough to determine that the individual qualifies for

admission and to develop a preliminary individualized services plan for individuals admitted to services. Employee or contractors responsible for screening, admitting and referral shall have immediate access to written service descriptions and admission criteria.

D. The provider shall assist individuals who are not admitted to identify other appropriate services.

E. The provider shall develop and implement [~~a policy on the qualifications of employees or contractors responsible for~~] for [~~providing~~] screening, [~~admission~~] and [~~referrals referring~~] [~~and resources for consultation~~] individuals to services, to include staff who are designated to perform these activities].

[~~F. The provider shall develop procedures for screening, admitting and referring individuals to services.~~]

12 VAC 35-105-640. Screening and referral services documentation and retention.

A. The provider shall maintain written documentation of each screening performed, including:

1. Date of initial contact;
2. Name, age, and gender of the individual;
3. Address and phone number, if applicable;
4. Presenting needs or situation to include psychiatric/medical problems, current medications and history of medical care;
5. Name of screening employee or contractor;
6. Method of screening;
7. Screening recommendation; and
8. Disposition of individual.

B. The provider shall retain documentation for each screening. For individuals not admitted, documentation shall be retained for six months. Documentation shall be included in the individual's record if the individual is admitted.

12 VAC 35-105-650. Assessment policy.

A. The provider shall document and implement an assessment policy. The policy shall define how assessments will be documented.

B. The provider shall conduct an assessment to identify an individual's physical, medical, behavioral, functional, and social strengths, preferences and needs, as applicable. The assessment shall address:

1. Onset/duration of problems;
2. Social/behavioral/developmental/family history;
3. Employment/vocation/educational background;
4. Previous interventions/outcomes;
5. Financial resources and benefits;
6. Health history and current medical care needs;

7. Legal status, including guardianship, commitment and representative payee status, and relevant criminal charges or convictions, probation or parole status;

8. Daily living skills;

9. Social/family supports;

10. Housing arrangements; and

11. Ability to access services.

C. The policy shall designate employees or contractors responsible for assessments. Employees or contractors responsible for assessments shall have experience in working with the population being assessed and with the assessment tool being utilized.

D. Frequency of assessments.

1. A preliminary assessment shall be done prior to admission;

2. The preliminary assessment shall be updated and finalized during the first 30 days of service prior to completing the individualized services plan. Longer term assessments may be included as part of the individualized services plan. The provider shall document the reason for assessments requiring more than 30 days.

3. Reassessments shall be completed when there is a need based on the medical, psychiatric or behavioral status of the individual and at least annually.

E. The provider shall make reasonable attempts to obtain previous assessments.

[~~F. This section does not apply to sobering-up services.~~]

12 VAC 35-105-660. Individualized services plan (ISP).

A. The provider shall develop a preliminary individualized services plan for the first 30 days. The preliminary individualized services plan shall be developed and implemented within 24 hours of admission and shall continue in effect until the individualized services plan is developed or the individual is discharged, whichever comes first.

B. The provider shall develop an individualized services plan for each individual as soon as possible after admission but no later than 30 days after admission. Providers of short-term services must develop and implement a policy to develop individualized services plans within a time frame consistent with the expected length of stay of individuals. Services requiring longer term assessments may include the completion of those as part of the individualized services plan as long as all appropriate services are incorporated into the individualized services plan based on the assessment completed within 30 days of admission and the individualized services plan is updated upon the completion of assessment.

C. The individualized services plan shall address:

[1. The individual's needs and preferences.]

[4. 2.] Relevant psychological, behavioral, medical, rehabilitation and nursing needs as indicated by the assessment;

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[~~2. 3.] Individualized strategies, including the intensity of services needed;~~

[~~3. 4.] A communication plan for individuals with communication barriers, including language barriers; [and]~~

[~~4. 5.] The behavior treatment plan, if applicable [~~÷ and~~ .]~~

[~~5. The individual's needs and preferences.]~~

D. The provider shall [~~document that it has followed~~ comply with] the human rights regulations in regard to participation in decision-making [~~(see 12 VAC 35-115-70)~~] by the individual or legally authorized representative in developing or revising the individualized services plan.

E. The provider shall involve family members, guardian, or others [, if appropriate,] in developing [, reviewing,] or revising [, at least annually,] the individualized [~~services plan~~ service plans] consistent with laws protecting confidentiality, privacy, the human rights of individuals receiving services (see 12 VAC 35-115-60) and the rights of minors.

F. Employees or contractors responsible for implementation of an individualized services plan shall demonstrate a working knowledge of the plan's goals, objectives and strategies.

G. The provider shall [~~develop and implement a written policy regarding the qualifications of personnel for developing an~~ designate a person who will develop and implement] individualized [~~services plan~~ service plans].

H. The provider shall implement the individualized services plan and review it at least every three months or whenever there is a revised assessment. These reviews shall evaluate the individual's progress toward meeting the plan's objectives. The goals, objectives and strategies of the individualized services plan shall be updated, if indicated.

[~~I. The provider shall review and rewrite the individualized services plan at least annually based on a current assessment and with the participation of the individual and his family.~~

[~~This section does not apply to sobering-up services.]~~

12 VAC 35-105-670. Individualized services plan requirements.

A. The individualized services plan shall include, at a minimum:

1. A summary or reference to the assessment;
2. Goals and measurable objectives for addressing each identified need;
3. The services and supports and frequency of service to accomplish the goals and objectives;
4. Target dates for accomplishment of goals and objectives;
5. Estimated duration of service plan;
6. Discharge plan, where applicable; and
7. The employees or contractors responsible for coordination and integration of services, including employees of other agencies.

B. The individualized services plan shall be signed and dated, at a minimum, by the person responsible for implementing the plan and the individual receiving services or the legally authorized representative. If unable to obtain the signature of the individual receiving services or the legally authorized representative, the provider shall document the reason.

[~~C. This section does not apply to sobering-up services.]~~

12 VAC 35-105-680. Progress notes or other documentation.

The provider shall use signed and dated progress notes or other documentation to document the services provided, and the implementation and outcomes of individualized services plans. [~~This section does not apply to sobering-up services.]~~

12 VAC 35-105-690. Orientation.

A. The provider shall develop and implement a written policy regarding orientation of individuals and the legally authorized representative to services.

B. At a minimum, the policy shall require the provision to individuals and the legally authorized representative of the following information, as appropriate to the scope and level of services:

1. The mission of the provider;
2. Confidentiality practices for individuals receiving services;
3. Human rights and how to report violations;
4. Participation in treatment and discharge planning;
5. Fire safety and emergency preparedness procedures;
6. The grievance procedure;
7. Service guidelines;
8. Physical plant or building lay-out;
9. Hours and days of operation; and
10. Availability of after-hours service.

C. In addition, individuals receiving treatment services in correctional facilities will receive orientation to security restrictions.

D. The provider shall document that orientation has been provided to individuals and the legal guardian/authorized representative.

[~~E. This section does not apply to sobering-up centers.]~~

Article 3.

Crisis Intervention and Clinical Emergencies.

12 VAC 35-105-700. Written policies and procedures for a crisis or clinical emergency; required elements.

A. The provider shall develop and implement written policies and procedures for prompt intervention in the event of a crisis or clinical emergency that occurs during screening and referral or during admission and service provision. A clinical emergency refers to either a medical or psychiatric emergency.

B. The policies and procedures shall include:

1. A definition of crisis and clinical emergency;
2. Procedures for stabilization and immediate access to appropriate internal and external resources including a provision for obtaining physician and mental health clinical services if on-call physician back up or mental health clinical services are not available;
3. Employee or contractor responsibilities; and
4. Location of emergency medical information for individuals receiving services, which shall be readily accessible in an emergency.

12 VAC 35-105-710. Documenting crisis intervention and clinical emergency services.

A. The provider shall develop a method for documenting the provision of crisis intervention and clinical emergency services. Documentation shall include the following:

1. Date and time;
2. Nature of crisis or emergency;
3. Name of individual;
4. Precipitating factors;
5. Interventions/treatment provided;
6. Employees or contractors involved; and
7. Outcome.

B. If a crisis or clinical emergency involves an individual who is admitted into service, the crisis intervention documentation shall become part of his record.

Article 4. Medical Management.

12 VAC 35-105-720. Health care policy.

A. The provider shall develop and implement a written policy, appropriate to the scope and level of service that addresses provision of adequate medical care. This policy shall describe how:

1. Medical care needs will be assessed;
2. Individualized services plans address any medical care needs appropriate to the scope and level of service;
3. [Identified] medical care needs [~~beyond the scope of services~~] will be [~~not~~ addressed];
4. The provider manages medical care needs or responds to abnormal findings;
5. The provider communicates medical assessments and diagnostic laboratory results to individuals and authorized representatives.
6. The provider keeps accessible to staff the names, addresses, phone numbers of medical and dental providers.
7. The provider [~~arranges for~~ ensures a means for facilitating and arranging, as appropriate,] transportation to

medical and dental appointments and medical tests [, when services cannot be provided on site].

B. Providers of residential or inpatient services shall either provide or arrange for the provision of appropriate medical care. A provider of other services shall define instances when it shall provide or arrange for appropriate medical and dental care and instances when it shall refer the individual to appropriate medical care.

12 VAC 35-105-730. Medical [~~evaluation~~ information].

A. The provider shall develop and implement a medical evaluation or document its ability to obtain a medical evaluation that consists of, at a minimum, a health history and emergency medical information.

B. A health history shall include:

1. Allergies;
2. Recent physical complaints and medical conditions;
3. Chronic conditions;
4. Communicable diseases;
5. Handicaps or restriction on physical activities, if any;
6. Past serious illnesses, serious injuries and hospitalizations;
7. Serious illnesses and chronic conditions of the individual's parents, siblings and significant others in the same household;
8. Current and past drug usage including alcohol, prescription and nonprescription medications, and illicit drugs; and

[~~9. Gynecological history, including pregnancies~~ Sexual health and reproductive history].

12 VAC 35-105-740. Physical examination.

A. The provider shall develop a policy on physical examinations in consultation with a qualified practitioner. Providers of residential services shall administer or obtain results of physical exams within 30 days of admission. Providers of inpatient services shall administer physical exams within 24 hours of admission.

B. A physical examination shall include, at a minimum:

1. General physical condition (history and physical);
2. Evaluation for communicable diseases;
3. Recommendations for further diagnostic tests and treatment, if appropriate;
4. Other examinations indicated, if appropriate; and
5. The date of examination and signature of a qualified practitioner.

C. Locations designated for physical examinations shall ensure individual privacy.

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12 VAC 35-105-750. Emergency medical information.

A. The provider shall maintain the following emergency medical information for each individual:

1. If available, the name, address, and telephone number of:
 - a. The individual's physician; and
 - b. A relative, legally authorized representative, or other person to be notified;
2. Medical insurance company name and policy or Medicaid, Medicare or CHAMPUS number, if any; and
3. Currently prescribed medications and over-the-counter medications used by the individual;
4. Medication and food allergies;
5. History of substance abuse;
6. Significant medical problems;
7. Significant communication problems; and
8. Advance directive [, if one exists].

B. Current emergency medical information shall be readily available to employees or contractors wherever program services are provided.

12 VAC 35-105-760. Medical equipment.

The provider shall develop and implement a policy on maintenance and use of medical equipment, including personal medical equipment and devices.

Article 5.

Medication Management Services.

12 VAC 35-105-770. Medication management.

A. The provider shall develop and implement written policies addressing:

1. The safe administration, handling, storage, and disposal of medications;
2. The use of medication orders;
3. The handling of packaged medications brought by individuals from home or other residences;
4. Employees or contractors authorized to administer medication and training required for administration of medication;
5. The use of professional samples; and
6. The window within which medications can be given in relation to the ordered time of administration.

B. Medications shall be administered only by persons authorized by state law.

C. Medications shall be [~~given~~ administered] only to the individuals for whom the medications are prescribed and shall be administered as prescribed.

D. The provider shall maintain a daily log of all medicines received and refused by each individual. This log shall identify the employee or contractor who administered the medication.

E. If the provider administers medications or supervises self-administration of medication in a service, a current medication order for all medications the individual receives shall be maintained on site.

F. The provider shall promptly dispose of discontinued drugs, outdated drugs, and drug containers with worn, illegible, or missing labels according to the applicable regulations of the Virginia Board of Pharmacy.

12 VAC 35-105-780. Medication errors and drug reactions.

[~~A.~~] In the event of a medication error or adverse drug reaction [~~, first :~~]

[1. First] aid shall be administered if indicated.

[~~B.~~ 2.] Employees or contractors shall promptly contact a poison control center, pharmacist, nurse or physician and shall take actions as directed.

[~~C.~~ 3.] The individual's physician shall be notified as soon as possible unless the situation is addressed in standing orders.

[~~D.~~ 4.] Actions taken by employees or contractors shall be documented.

[~~E.~~ 5.] The provider shall [~~keep a log of all~~ review] medication errors [~~and review it~~] at least quarterly as part of the quality assurance in 12 VAC 35-105-620.

[~~F.~~ 6.] Medication errors and adverse drug reactions shall be recorded in the individual's medication log.

12 VAC 35-105-790. Medication administration and storage or pharmacy operation.

A. The provider responsible for medication administration and [medication] storage or pharmacy operations shall comply with:

1. The Drug Control Act (§ 54.1-3400 et seq. of the Code of Virginia);

2. The Virginia Board of Pharmacy regulations (18 VAC 110-20); [~~and~~]

[3. The Virginia Board of Nursing regulations and Medication Administration Curriculum (18 VAC 90-20-370 through 18 VAC 90-20-390); and]

[~~3.~~ 4.] Applicable federal laws and regulations relating to controlled substances.

B. The provider responsible for medication administration and storage or pharmacy operation shall provide in-service training to employees and consultation to individuals or legally authorized representatives on issues of basic pharmacology including medication side effects.

Article 6.
Behavior Management.

12 VAC 35-105-800. Policies and procedures on behavior management techniques.

A. The provider shall develop and implement written policies and procedures that describe the use of behavior management techniques, including seclusion, restraint, and time out. The policies and procedures shall:

1. Be consistent with applicable federal and state laws and regulations;
2. Emphasize positive approaches to behavior management;
3. List and define behavior management techniques in the order of their relative degree of intrusiveness or restrictiveness and the conditions under which they may be used in each service for each individual;
4. Protect the safety and well-being of the individual at all times, including during fire and other emergencies;
5. Specify the mechanism for monitoring the use of behavior management techniques; and
6. Specify the methods for documenting the use of behavior management techniques.

B. The behavior management policies and procedures shall be developed, implemented, and monitored by employees or contractors trained in behavior management programming.

C. Policies and procedures related to behavior management shall be available to individuals, their families, guardians and advocates except that it does not apply to services provided in correctional facilities.

D. Individuals receiving services shall not discipline, restrain, seclude or implement behavior management techniques on other individuals receiving services.

E. Injuries resulting from or occurring during the implementation of behavior management techniques shall be recorded in the clinical record and reported to the employee or contractor responsible for the overall coordination of services.

12 VAC 35-105-810. Behavioral treatment plan.

A behavioral treatment plan may be developed as part of the individualized services plan in response to behavioral needs identified through the assessment process. A behavioral treatment plan may include restrictions only if the plan has been developed according to procedures outlined in the human rights regulations. Behavioral treatment shall be developed, implemented and monitored by employees or contractors trained in behavioral treatment.

12 VAC 35-105-820. Prohibited actions.

The following actions shall be prohibited:

1. Prohibition of contacts and visits with attorney, probation officer, placing agency representative, minister or chaplain;
2. Any action that is humiliating, degrading, or abusive;
3. Corporal punishment;

4. Subjection to unsanitary living conditions;

5. Deprivation of opportunities for bathing or access to toilet facilities except as ordered by a licensed physician for a legitimate medical purpose and documented in the individual's record;

6. Deprivation of appropriate services and treatment;

7. Deprivation of health care;

8. Administration of laxatives, enemas, or emetics except as ordered by a physician or other professional acting within the scope of his license for a legitimate medical purpose and documented in the individual's record;

9. Applications of aversive stimuli except as permitted pursuant to other applicable state regulations;

10. Limitation on contacts with regulators, advocates or staff attorneys employed by the department or the Department for the Rights of Virginians with Disabilities.

11. Deprivation of drinking water or food necessary to meet an individual's daily nutritional needs except as ordered by a licensed physician for a legitimate medical purpose and documented in the individual's record;

12. Prohibition on contacts and visits with family or legal guardian except as permitted by other applicable state regulations or by order of a court of competent jurisdiction;

13. Delay or withholding of incoming or outgoing mail except as permitted by other applicable state and federal regulations or by order of a court of competent jurisdiction; and

14. Deprivation of opportunities for sleep or rest except as ordered by a licensed physician for a legitimate medical purpose and documented in the individual's record.

12 VAC 35-105-830. Seclusion, restraint, and time out.

A. The use of seclusion, restraint, and time out shall comply with applicable federal and state laws and regulations and be consistent with the provider's policies and procedures.

B. Devices used for mechanical restraint shall be designed specifically for behavior management of human beings in clinical or therapeutic programs.

C. Application of time out, seclusion and restraint shall be documented in the individual's record and, at a minimum, include:

1. Physician's order;
2. Date and time;
3. Employees or contractors involved;
4. Circumstances and reasons for use, including but not limited to other behavior management techniques attempted;
5. Duration;
6. Type of technique used; and
7. Outcomes, including documentation of debriefing of the individual and staff involved following the incident.

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12 VAC 35-105-840. Requirements for seclusion room.

A. The room used for seclusion shall meet the design requirements for buildings used for detention or seclusion of persons.

B. The seclusion room shall be at least six feet wide and six feet long with a minimum ceiling height of eight feet.

C. The seclusion room shall be free of all protrusions, sharp corners, hardware, fixtures or other devices which may cause injury to the occupant.

D. Windows in the seclusion room shall be so constructed as to minimize breakage and otherwise prevent the occupant from harming himself.

E. Light fixtures and other electrical receptacles in the seclusion room shall be recessed or so constructed as to prevent the occupant from harming himself. Light controls shall be located outside the seclusion room.

F. Doors to the seclusion room shall be at least 32 inches wide, shall open outward and shall contain observation view panels of transparent wire glass or its approved equivalent, not exceeding 120 square inches but of sufficient size for someone outside the door to see into all corners of the room.

G. The seclusion room shall contain only a mattress with a washable mattress covering designed to avoid damage by tearing.

H. The seclusion room shall maintain temperatures appropriate for the season.

I. All space in the seclusion room shall be visible through the locked door, either directly or by mirrors.

Article 7.

Continuity of Service and Discharge.

12 VAC 35-105-850. Transition of individuals among services.

A. The provider shall have written procedures to define the process for the transition of an individual among services of the provider. At a minimum, the policy will address:

1. Continuity of service;
2. Participation of the individual and his family;
3. Transfer of the individual's record;
4. Transfer summary; and
5. Where applicable, discharge and admission summaries.

B. The transfer summary will include at a minimum:

1. The originating service;
2. The destination service;
3. Reason for transfer;
4. Current psychiatric and medical condition of the individual;
5. Updated progress on meeting the goals and objectives of the ISP;

6. Medications and dosages in use;

7. Transfer date; and

8. Signature of employee or contractor responsible for preparing the transfer summary.

12 VAC 35-105-860. Discharge.

A. The provider shall have written policies and procedures regarding the discharge of individuals from the service and termination of services. These policies and procedures shall include medical or clinical criteria for discharge.

[B. Discharge instructions shall be provided, in writing, to the individual or his legally authorized representative or both. Discharge instructions shall include, at a minimum, medications and dosages, phone numbers and addresses of any providers to whom the individual is referred, current medical issues, conditions, and the identity of health care providers. This regulation applies to residential and inpatient services.]

[~~B. C.~~] The provider shall make appropriate arrangements or referrals to all services identified by the discharge plan prior to the individual's scheduled discharge date.

[~~C. D.~~] Discharge planning and discharge shall be consistent with the individualized services plan and the criteria for discharge.

[~~D. E.~~] The individual's, the individual's legally authorized representative and the individual's family's involvement in discharge planning shall be documented in the individual's service record.

[~~E. F.~~] A written discharge summary shall be completed within 30 days of discharge and shall include, at a minimum, the:

1. Reason for admission and discharge;
2. Individual's participation in discharge planning;
3. Individual's level of functioning or functional limitations, if applicable;
4. Recommendations on procedures, activities, or referrals to assist the individual in maintaining or improving functioning and increased independence and the status, location and arrangements for future services that have been made;
5. Progress made achieving the goals and objectives identified in the individualized services plan and summary of critical events during service provision;
6. Discharge date;
7. Discharge medications, if applicable;
8. Date the discharge summary was actually written/documented; and
9. Signature of person who prepared summary.

PART V.
RECORDS MANAGEMENT.

~~[Article 4.
Records Management.]~~

12 VAC 35-105-870. Written records management policy.

A. The provider shall develop and implement a written records management policy that shall describe confidentiality, accessibility, security, and retention of records pertaining to individuals, including:

1. Access, duplication and dissemination of information only to persons legally authorized according to federal and state laws;
2. Storage, processing and handling of active and closed records;
3. Storage, processing and handling of electronic records;
4. Security measures to protect records from loss, unauthorized alteration, inadvertent or unauthorized access, disclosure of information and transportation of records between service sites; physical and data security controls shall exist for electronic records;
5. Designation of person responsible for records management; and
6. Disposition of records in event the service ceases operation. If the disposition of records would involve a transfer to another provider, the provider shall have a written agreement with that provider.

B. The records management policy shall be consistent with state and federal laws and regulations including:

1. Section 32.1-127.1:03 of the Code of Virginia;
2. 42 USC § 290dd;
3. 42 CFR Part 2; and
4. Health Insurance Portability and Accountability Act (Public Law 104-191, 42 USC § 300gg et seq.) and implementing regulations (42 CFR Part 146).

12 VAC 35-105-880. Documentation policy.

A. The provider shall define, by policy, all records it maintains that address an individual's care and treatment and what each record contains.

B. The provider shall define, by policy, a system of documentation which supports appropriate service planning, coordination, and accountability. At a minimum this policy shall outline:

1. The location of the individual's record;
2. Methods of access by employees or contractors to the individual's record; and
3. Methods of updating the individual's record by employees or contractors including frequency and format.

C. Entries in the individual's record shall be current, dated, and authenticated by the person making the entry. Errors shall be corrected by striking through and initialing. If records are

electronic, the provider shall develop and implement a policy to identify corrections of the record.

12 VAC 35-105-890. Individual's service record.

A. There shall be a single, separate primary record for each individual or family admitted for service. A separate record shall be maintained for each family member who is receiving individual treatment.

B. All individuals admitted to the service shall have identifying information on the face sheet in the individual's service record. Identifying information on a standardized face sheet or sheets shall include the following:

1. Identification number unique for the individual;
2. Name of individual;
3. Current residence, if known;
4. Social security number;
5. Gender;
6. Marital status;
7. Date of birth;
8. Name of legal guardian or authorized representative [, if applicable];
9. Name, address, and telephone number for emergency contact;
10. Adjudicated legal incompetency or legal incapacity [, if applicable]; and
11. Date of admission to service.

C. In addition to the face sheet, an individual's service record shall contain, at a minimum:

- ~~[1. The admission form;]~~
~~[2. 1.]~~ Screening documentation;
~~[3. 2.]~~ Assessments;
~~[4. 3.]~~ Medical evaluation, as applicable to the service;
~~[5. 4.]~~ Individualized services plans and reviews;
~~[6. 5.]~~ Progress notes; and
~~[7. 6.]~~ A discharge summary, if applicable.

12 VAC 35-105-900. Record storage and security.

A. When not in use, active and closed records shall be stored in a locked cabinet or room.

B. Physical and data security controls shall exist for electronic records.

12 VAC 35-105-910. Retention of individual's service records.

A. An individual's service records shall be kept for a minimum of three years after discharge or date of last contact unless otherwise specified by state or federal requirements.

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B. Permanent information kept on each individual shall include:

1. Individual's name;
2. Social security number;
3. Date of individual's birth;
4. Dates of admission and discharge; and
5. Name and address of legal guardian, if any.

12 VAC 35-105-920. Review process for records.

The provider shall implement a review process to evaluate both current and closed records for completeness, accuracy, and timeliness of entries.

PART VI. ADDITIONAL REQUIREMENTS FOR SELECTED SERVICES.

Article 1. Opioid Treatment Services.

12 VAC 35-105-930. Registration, certification or accreditation.

A. The opioid treatment service shall maintain current registration or certification with:

1. The Federal Drug Enforcement Administration;
2. The Federal Department of Health and Human Services; and
3. The Virginia Board of Pharmacy.

B. If required by federal regulations, a provider of opioid treatment services shall be required to maintain accreditation with an entity approved under federal regulations.

12 VAC 35-105-940. Criteria for involuntary termination from treatment.

A. The provider shall establish criteria for involuntary termination from treatment that describe the rights of the individual receiving services and the responsibilities and rights of the provider.

B. The provider shall establish a grievance procedure as part of the rights of the individual.

C. On admission, the individual shall be given a copy of the criteria and shall sign a statement acknowledging receipt of same. The signed acknowledgement shall be maintained in the individual's record.

12 VAC 35-105-950. Service operation schedule.

A. The service's days of operation shall meet the needs of the population served. If the service dispenses or administers a medication requiring daily dosing, the service shall operate seven days a week, 12 months a year, except for official state holidays. Prior approval from the state authority shall be required for additional closed days.

B. Medication dispensing hours shall include at least two hours each day of operation outside normal working hours, i.e., before 9 a.m. and after 5 p.m. The state authority may

approve an alternative schedule if that schedule meets the needs of the population served.

12 VAC 35-105-960. Physical examinations.

A. The individual shall have a complete physical evaluation prior to admission to the service unless the individual is transferring from another licensed opioid agonist service. A full physical examination, including the results of serology and other tests, shall be completed within 14 days of admission.

B. Physical exams of each individual shall be completed annually or more frequently if there is a change in the individual's physical or mental condition.

C. The provider shall maintain the report of the individual's physical examination in the individual's service record.

12 VAC 35-105-970. Counseling sessions.

The provider shall conduct face-to-face counseling sessions (either individual or group) at least every two weeks for the first year of treatment and every month in the second year. After two years, the number of face-to-face counseling sessions shall be based on progress in treatment. Absences shall be addressed as part of the overall treatment process.

12 VAC 35-105-980. Drug screens.

A. The provider shall perform [~~random drug screens: 1. Weekly, during the first 30 days of treatment;~~ at least eight random drug screens during a 12-month period unless the conditions in subdivision B of this subsection apply;]

[~~2. Monthly, after the first 30 days of treatment, unless the conditions in subdivision 3 of this subsection apply; and B. Whenever an individual's drug screen indicates continued illicit drug use or when clinically and environmentally indicated, random drug screens shall be performed weekly.]~~

[~~3. Weekly, whenever an individual's drug screen indicates continued illicit drug use or an individual fails to participate in the treatment plan.]~~

[~~B. C.]~~ Drug screens shall be analyzed for opiates, methadone (if ordered), benzodiazepines and cocaine. In addition, drug screens for other drugs with potential for addiction shall be performed when clinically and environmentally indicated.

[~~G. D.]~~ The provider shall develop and implement a policy on how the results of drug screens shall be used to direct treatment.

12 VAC 35-105-990. Take-home medication.

A. Prior to dispensing regularly scheduled take-home medication, the provider shall ensure the individual demonstrates a level of current lifestyle stability as evidenced by the following:

1. Regular clinic attendance;
2. Absence of recent alcohol [abuse] and other [illicit] drug use;
3. Absence of significant behavior problems; and

4. Absence of recent criminal activities, charges or convictions.

B. The provider shall educate the individual on the safe transportation and storage of take-home medication.

12 VAC 35-105-1000. Preventing duplication of medication services.

To prevent duplication of opioid medication services to an individual, the provider shall have a policy and implement procedures to contact every opioid treatment service within a 50-mile radius before admitting an individual.

12 VAC 35-105-1010. Guests.

A. No medication shall be dispensed to any guest unless the guest has been receiving such medication services from another provider and documentation from such provider has been received prior to dispensing medication.

B. Guests may receive medication for up to 28 days. To continue receiving medication after 28 days, the guest must be admitted to the service. Individuals receiving guest medications as part of a residential treatment service may exceed the 28-day maximum time limit.

12 VAC 35-105-1020. Detoxification prior to involuntary discharge.

Individuals who are being involuntarily discharged shall be given an opportunity to detoxify from opioid agonist medication not less than 10 days or not more than 30 days prior to discharge from the service, unless the state authority has granted an exception.

12 VAC 35-105-1030. Opioid agonist medication renewal.

Physician orders for opioid agonist medication shall be reevaluated and renewed at least every six months.

12 VAC 35-105-1040. Emergency preparedness plan.

The emergency preparedness plan shall include provision for the continuation of opioid treatment in the event of an emergency or natural disaster.

12 VAC 35-105-1050. Security of opioid agonist medication supplies.

A. At a minimum, opioid agonist medication supplies shall be secured as follows:

1. Admittance to the medication area shall be restricted to medical or pharmacy personnel;
2. Medication inventory shall be reconciled monthly; and
3. Inventory records, including the monthly reconciliation, shall be kept for three years.

B. The provider shall maintain a current plan to control the diversion of medication to unprescribed or illegal uses.

Article 2.

[~~Sobering-Up and Social~~] Detoxification Services.

[~~12 VAC 35-105-1060. Criminal justice referrals.~~

~~The provider shall develop and implement written policies and procedures for accepting criminal justice referrals in~~

~~conjunction with the chief law enforcement officer and the chief general district court judge of the localities served.]~~

[~~12 VAC 35-105-1070. 12 VAC 35-105-1060.] Cooperative agreements with community agencies.~~

~~The provider shall establish cooperative agreements with other community agencies to accept referrals for treatment, including provisions for physician coverage and emergency medical care. The agreements shall clearly outline the responsibility of each party.~~

[~~12 VAC 35-105-1080. Rest, holding or admission areas. 12 VAC 35-105-1070. Observation area.]~~

~~[A. The provider shall provide for rest, holding, or admission areas with:~~

- ~~1. Adequate space for individuals to sleep and sober up;~~
- ~~2. Unobstructed observation by employees or contractors;~~
- ~~3. Nearby bathrooms;~~
- ~~4. Available drinking water; and~~
- ~~5. Access to showers.~~

~~B.] The provider shall provide for designated areas for employees and contractors with unobstructed observation of individuals.~~

[~~12 VAC 35-105-1090. 12 VAC 35-105-1080.] Direct-care training for providers of [~~sobering-up and~~] detoxification services.~~

~~A. [Direct-care training and certification shall include Department of Mental Health, Mental Retardation and Substance Abuse Services Managed Withdrawal Training and The provider shall document staff training in the areas of]:~~

- ~~[1. Management of withdrawal; and]~~
- ~~[4. 2.] First responder training; or~~
- ~~[2. 3. First aid and CPR training.~~

~~B. New employees or contractors shall be trained within 30 days of employment. Untrained employees or contractors shall not be solely responsible for the care of individuals.~~

[~~12 VAC 35-105-1100. 12 VAC 35-105-1090.] Minimum number of employees or contractors on duty.~~

~~[A. The providers shall establish staffing patterns based on the needs and number of individuals served.]~~

~~[B.] In [~~free-standing sobering-up or~~] detoxification service locations, at least two employees or contractors shall be on duty at all times. If the location is within or contiguous to another service location, at least one employee or contractor shall be on duty at the location with trained backup employees or contractors immediately available.~~

[~~12 VAC 35-105-1110. 12 VAC 35-105-1100.] Documentation.~~

~~Employees or contractors shall document services provided and significant events in the individual's record on each shift. [This regulation applies to sobering-up services.]~~

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[~~12 VAC 35-105-1120.~~ 12 VAC 35-105-1110.] **Admission assessments.**

[~~A.~~] During the admission process, providers of [~~sobering-up and~~] detoxification services shall:

1. Identify individuals with a high-risk [~~profile~~ for medical complications or who may pose a danger to themselves or others];
2. Assess substances used and time of last use;
3. Determine time of last meal;
4. Administer a urine screen;
6. Analyze blood alcohol content or administer a breathalyzer; and
7. Record vital signs.

[~~B. The provider shall develop and implement written procedures to address situations when an individual refuses to participate in the assessment process. The provider shall document all refusals and follow-up actions taken.~~]

[~~12 VAC 35-105-1130.~~ 12 VAC 35-105-1120.] **Vital signs.**

A. Unless the individual refuses, the provider shall take vital signs:

1. At admission and discharge;
2. Every four hours for the first 24 hours and every eight hours thereafter; and
3. As frequently as necessary, until signs and symptoms stabilize for individuals with a high-risk profile.

B. The provider shall have procedures to address situations when an individual refuses to have vital signs taken.

C. The provider shall document vital signs, all refusals and follow-up actions taken.

[~~12 VAC 35-105-1140.~~ **First aid equipment.**

~~The provider shall have first aid equipment that is easily accessible in a well-marked location and includes a blood pressure cuff, stethoscope and thermometer. Other required first aid equipment includes bandages, saline solution, adhesive bandages, sterile gauze, latex gloves, tweezers, instant ice pack, adhesive tape and antiseptic soap.~~

~~12 VAC 35-105-1150.~~ 12 VAC 35-105-1130.] **Light snacks and fluids.**

The provider shall offer light snacks and fluids to individuals who are not in danger of aspirating.

Article 3.

Services in [Department of Corrections] Correctional Facilities.

[~~12 VAC 35-105-1160.~~ 12 VAC 35-105-1140.] **Clinical and security coordination.**

A. The provider shall have formal and informal methods of resolving procedural and programmatic issues regarding individual care arising between the clinical and security employees or contractors.

B. The provider shall demonstrate ongoing communication between clinical and security employees to ensure individual care.

C. The provider shall provide cross-training for the clinical and security employees or contractors that includes:

1. Mental health, mental retardation, and substance abuse education;
2. Use of clinical and security restraints; and
3. Channels of communication.

D. Employees or contractors shall receive periodic in-service training, have knowledge of and be able to demonstrate the appropriate use of clinical and security restraint.

E. Security and behavioral assessments shall be completed at the time of admission to determine service eligibility and at least weekly for the safety of individuals, other persons, employees, and visitors.

F. Personal grooming and care services for individuals shall be a cooperative effort between the clinical and security employees or contractors.

G. Clinical needs and security level shall be considered when arrangements are made regarding privacy for individual contact with family and attorneys.

H. Living quarters shall be assigned on the basis of the individual's security level and clinical needs.

I. An assessment of the individual's clinical condition and needs shall be made when disciplinary action or restrictions are required for infractions of security measures.

J. Clinical services consistent with the individual's condition and plan of treatment shall be provided when security detention or isolation is imposed.

[~~12 VAC 35-105-1170.~~ 12 VAC 35-105-1150.] **Other requirements for correctional facilities.**

A. Group bathroom facilities shall be partitioned between toilets and urinals to provide privacy.

B. If uniform clothing is required, the clothing shall be properly fitted, climatically suitable, durable, and presentable.

C. Financial compensation for work performed shall be determined by the Department of Corrections. Personal housecleaning tasks may be assigned without compensation to the individual.

D. The use of audio equipment, such as televisions, radios, and record players, shall not interfere with therapeutic activities.

E. Aftercare planning for individuals nearing the end of incarceration shall include provision for continuing medication and follow-up services with area community services to facilitate successful reintegration into the community including specific appointment provided to the inmate no later than the day of release.

Article 4.

Sponsored Residential Home Services.

[~~12 VAC 35-105-1180.~~ 12 VAC 35-105-1160.] **Sponsored residential home information.**

Providers of sponsored residential home services shall maintain the following information:

1. Names and ages of residential sponsors;
2. Date of sponsored residential home agreement;
3. The maximum number of individuals that can be placed in the home;
4. Names and ages of all other individuals not receiving services, but residing in a sponsored residential home;
5. Address and telephone number of the sponsored residential home; and
6. All staff employed in the home, including on-call and substitute staff.

[~~12 VAC 35-105-1190.~~ 12 VAC 35-105-1170.] **Sponsored residential home agreements.**

The provider shall maintain a written agreement with residential home sponsors. Sponsors are individuals who provide the home where the service is located and are directly responsible for the provision of services. The agreement shall:

1. Be available for inspection by the licensing specialist; and
2. Include a provision for granting the right of entry to state licensing specialists or human rights advocates to investigate complaints.

[~~12 VAC 35-105-1200.~~ 12 VAC 35-105-1180.] **Sponsor qualification and approval process.**

A. The provider shall evaluate sponsored residential homes other than his own through face-to-face interviews, home visits, and other information before individuals are placed in the home.

B. The provider shall certify that all sponsored residential homes meet the criteria for physical environment and residential services designated in these regulations.

C. The provider shall document the sponsored staff's ability to meet the needs of the individuals placed in the home by assessing and documenting:

1. The sponsored staff's ability to communicate and understand individuals receiving services;
2. The sponsored staff's ability to provide the care, treatment, training or habilitation for individual receiving services in the home;
3. The abilities of all members of the household to accept individuals with disabilities and their disability-related characteristics, especially the ability of children in the household to adjust to nonfamily members living with them; and

4. The financial capacity of the sponsor to meet the sponsor's own expenses [for up to 90 days,] independent of payments received for residents living in the home.

D. The provider shall obtain references, criminal background checks and a search of the registry of founded complaints of child abuse and neglect maintained by the Department of Social Services for all adults in the home [who are staff. The provider must develop policies for obtaining references, background and registry checks for all adults in the home who are not staff and not the individuals being served].

E. Sponsored residential home members shall submit to the provider the results of a physical and mental health examination when requested by the provider based on indications of a physical or mental health problem.

F. Sponsored residential homes shall not also operate as group homes [or Department of Social Services approved] or foster homes.

[~~12 VAC 35-105-1210.~~ 12 VAC 35-105-1190.] **Sponsored residential home service policies.**

A. The provider shall develop and implement policies to provide orientation and supportive services to sponsored staff specific to individual receiving services.

B. The provider shall develop and implement a training plan for the sponsored staff consistent with resident needs.

C. The provider shall specify staffing arrangements in all homes, including on-call and substitute care.

D. The provider shall develop and implement a policy on managing, monitoring and supervising sponsored residential homes.

E. The provider shall conduct at least semi-annual unannounced visits to sponsored residential homes other than his own.

F. On an on-going basis and at least annually, the provider shall review compliance of sponsored residential homes and sponsors with regulations related to sponsored residential homes.

G. The provider shall develop policies regarding termination of a sponsored residential home.

[~~12 VAC 35-105-1220.~~ 12 VAC 35-105-1200.] **Supervision.**

A. A responsible adult shall be available to provide supervision to the individual as specified in the individualized service plan.

B. Any member of the [sponsor] family who transports individuals receiving services must have a valid driver's license and automobile liability insurance. The vehicle used to transport individuals receiving services shall have a valid registration and inspection sticker.

C. The sponsor shall inform the provider in advance of any anticipated additions or changes in the home or as soon as possible after an unexpected change occurs.

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[~~12 VAC 35-105-1230.~~ 12 VAC 35-105-1210.] Sponsored residential home service records.

Providers of sponsored residential home services shall maintain records on each sponsored residential home, which shall include:

1. Documentation of references;
2. Criminal background checks and results of the search of the registry of founded complaints of child abuse and neglect on all ~~[individuals residing adults who are staff]~~ in the home ~~[over the age of 21 who are not individuals receiving services]~~;
3. Orientation and training provided by the provider;
4. A log of [provider] visits to each sponsored residential home including the date, the [staff] person visiting, the purpose of the visit, and any significant events; and
5. The sponsor will maintain a daily log of significant events related to individuals receiving services.

[~~12 VAC 35-105-1240.~~ 12 VAC 35-105-1220.] Regulations pertaining to employees.

Providers will certify compliance of sponsors with regulations pertaining to employees.

[~~12 VAC 35-105-1250.~~ 12 VAC 35-105-1230.] Maximum number of beds or occupants in sponsored residential home.

The maximum number of sponsored residential home beds is two. The maximum number of occupants in a sponsored residential home is seven.

Article 5.
Case Management Services.

[~~12 VAC 35-105-1260.~~ 12 VAC 35-105-1240.] Service requirements for providers of case management services.

A. ~~[Providers of case management services shall identify and contact potential individuals to identify their needs for services. As part of the intake assessment, the provider of case management services shall identify individuals whose needs may be addressed through case management services.]~~

B. Providers of case management services shall document that the services below are performed consistent with the individual's assessment and individualized services plan.

1. Enhancing community integration through increased opportunities for community access and involvement and creating opportunities to enhance community living skills to promote community adjustment including, to the maximum extent possible, the use of local community resources available to the general public;
2. Making collateral contacts with the individual's significant others with properly authorized releases to promote implementation of the individual's individualized services plan and his community adjustment;

3. Assessing needs and planning services to include developing a case management individualized services plan;

4. Linking the individual to ~~[services and supports specified in the individualized services plan, including primary medical care]~~ those community supports that are likely to promote the personal habilitative/rehabilitative and life goals of the individual as developed in the individualized service plan (ISP)];

5. Assisting the individual directly to locate, develop, or obtain needed services, resources, and appropriate public benefits;

6. Assuring the coordination of services and service planning within a provider agency, with other providers and with other human service agencies and systems, such as local health and social services departments;

7. Monitoring service delivery through contacts with [individuals receiving services,] service providers and periodic site and home visits [to assess the quality of care and satisfaction of the individual];

8. Providing follow up instruction, education and counseling to guide the individual and develop a supportive relationship that promotes the individualized services plan;

9. Advocating for individuals in response to their changing needs, based on changes in the individualized services plan;

10. Developing a crisis plan for an individual ~~[as needed]~~ that includes the individual's references regarding treatment in an emergency situation];

11. Planning for transitions in individual's lives; and

12. Knowing and monitoring the individual's health status, any medical conditions, and his medications and potential side effects, and assisting the individual in accessing primary care and other medical services, as needed.

[~~12 VAC 35-105-1270.~~ 12 VAC 35-105-1250.] Qualifications of case management employees or contractors.

A. Employees or contractors providing case management services shall have knowledge of:

1. Services and systems available in the community including primary health care, support services, eligibility criteria and intake processes and generic community resources;
2. The nature of serious mental illness, mental retardation and/or substance abuse depending on the population served, including clinical and developmental issues;
3. Different types of assessments, including functional assessment, and their uses in service planning;
4. Treatment modalities and intervention techniques, such as behavior management, independent living skills training, supportive counseling, family education, crisis intervention, discharge planning and service coordination;

5. Types of mental health, mental retardation and substance abuse programs available in the locality;

6. The service planning process and major components of a service plan;

7. The use of medications in the care or treatment of the population served; and

8. All applicable federal and state laws, state regulations and local ordinances.

B. Employees or contractors providing case management services shall have skills in:

1. Identifying and documenting an individual's need for resources, services, and other supports;

2. Using information from assessments, evaluations, observation, and interviews to develop service plans;

3. Identifying ~~[services and resources within the community and established service system to meet the individual's needs,~~ and documenting how resources, services and natural supports such as family can be utilized to promote achievement of an individual's personal habilitative/rehabilitative and life goals;] and

4. Coordinating the provision of services by diverse public and private providers.

C. Employees or contractors providing case management services shall have abilities to:

1. Work as team members, maintaining effective inter- and intra-agency working relationships;

2. Work independently performing position duties under general supervision; and

3. Engage and sustain ongoing relationships with individuals receiving services.

[~~12 VAC 35-105-1280. Screening, referral and admission.~~

~~Maintaining waiting lists for services, case management tracking and periodically contacting individuals for the purpose of determining the potential need for services shall be considered screening and referral and not admission into licensed case management services.]~~

Article 6.

Community Gero-Psychiatric Residential Services.

[~~12 VAC 35-105-1290. 12 VAC 35-105-1260.] Admission criteria.~~

An individual receiving community gero-psychiatric residential services shall have had a medical, psychiatric, and behavioral evaluation to determine that he cannot be appropriately cared for in a nursing home or other less intensive level of care but does not need inpatient care.

[~~12 VAC 35-105-1300. 12 VAC 35-105-1270.] Physical environment requirements of community gero-psychiatric residential services.~~

A. Providers shall be responsible for ensuring safe mobility and unimpeded access to programs or services by installing and maintaining ramps, handrails, grab bars, elevators,

protective surfaces and other assistive devices or accommodations as determined by periodic review of the needs of the individuals being served. Entries, doors, halls and program areas, including bedrooms, must have adequate room to accommodate wheel chairs and allow for proper transfer of individuals. Single bedrooms shall have at least 100 square feet and multi-bed rooms shall have 80 square feet per individual.

B. Floors must have resilient, nonabrasive, and slip-resistant floor surfaces and floor coverings that promote mobility in areas used by individuals and promote maintenance of sanitary conditions.

C. Temperatures shall be maintained between 70°F and 80°F throughout resident areas.

D. Bathrooms, showers and program areas must be accessible to individuals. There must be at least one bathing unit available by lift, door or swivel-type tub.

E. Areas must be provided for quiet and recreation.

F. Areas must be provided for charting, storing of administrative supplies, a utility room, employee hand washing, dirty linen, clean linen storage, clothes washing, and equipment storage.

[~~12 VAC 35-105-1310. 12 VAC 35-105-1280.] Monitoring.~~

Employees or contractors regularly monitor individuals in all areas of the residence to ensure safety.

[~~12 VAC 35-105-1320. 12 VAC 35-105-1290.] Service requirements for providers of gero-psychiatric residential services.~~

A. Providers shall provide mental health, nursing and rehabilitative services; medical and psychiatric services; and pharmaceutical services for each individual as specified in the individualized services plan.

B. Providers shall provide crisis stabilization services.

C. Providers shall develop and implement written policies and procedures that support an active program of mental health and behavioral management directed toward assisting each individual to achieve outcomes consistent with the highest level of self-care, independence and quality of life. Programming may be on-site or at another location in the community.

D. Providers shall develop and implement written policies and procedures that respond to the nursing needs of each individual to achieve outcomes consistent with the highest level of self-care, independence and quality of life. Providers shall be responsible for:

1. Providing each individual services to prevent clinically avoidable complications, including but not limited to: skin care, dexterity and mobility, continence, hydration and nutrition;

2. Giving each individual proper daily personal attention and care, including skin, nail, hair and oral hygiene, in addition to any specific care ordered by the attending physician;

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3. Dressing each individual in clean clothing and encouraging each individual to wear day clothing when out of bed;

4. Providing each individual tub or shower baths as often as needed, but not less than twice weekly, or a sponge bath daily if the medical condition prohibits tub or shower baths.

5. Providing each individual appropriate pain management; and

6. Ensuring that each individual has his own personal utensils, grooming items, adaptive devices and other personal belongings including those with sentimental value.

E. Providers shall integrate behavioral/mental health care and medical/nursing care in the individualized services plan.

F. Providers shall have available nourishment between scheduled meals.

[~~12 VAC 35-105-1330.~~ 12 VAC 35-105-1300.] **Staffing requirements for community gero-psychiatric residential services.**

A. Community gero-psychiatric residential services shall be under the direction of a:

1. Program director with experience in gero-psychiatric services.

2. Medical director.

3. Director of clinical services who is a registered nurse with experience in gero-psychiatric services.

B. Providers shall provide qualified nursing supervisors, nurses, and certified nurse aides on all shifts, seven days per week, in sufficient number to meet the assessed nursing care and behavioral management needs determined by the individualized services plans.

C. Providers shall provide qualified staff for behavioral, psychosocial rehabilitation, rehabilitative, mental health, or recreational programming to meet the needs determined by the individualized services plan. These services shall be under the direction of a registered nurse, licensed psychologist, licensed clinical social worker, or licensed therapist.

[~~12 VAC 35-105-1340.~~ 12 VAC 35-105-1310.] **Interdisciplinary services planning team.**

A. At a minimum, a registered nurse, a licensed psychologist, a licensed social worker, a therapist (recreational, occupational or physical therapist), a pharmacist, and a psychiatrist shall participate in the development and review of the individualized services plan. Other employees or contractors as appropriate shall be included.

B. The interdisciplinary services planning team shall meet to develop the individualized services plans and review it quarterly. Members of the team shall be available for consultation on an as needed basis.

C. The interdisciplinary services planning team shall review the medications prescribed at least quarterly and consult with the primary care physician as needed.

D. The interdisciplinary services planning team shall integrate medical care plans prescribed by the primary care physician into the individualized services plan and consult with the primary care physician as needed.

[~~12 VAC 35-105-1350.~~ 12 VAC 35-105-1320.] **Employee or contractor qualifications and training.**

A. A nurse aide may be employed only if he is certified by the Board of Nursing. During the initial 120 days of employment, a nurse aide may be employed if he is enrolled full-time in a nurse aide education program approved by the Virginia Board of Nursing or has completed a nurse aide education program or competency testing.

B. All nursing employees or contractors, including certified nursing assistants, must have additional competency-based training in providing mental health services to geriatric individuals, including behavior management.

[~~12 VAC 35-105-1360.~~ 12 VAC 35-105-1330.] **Medical director.**

Providers of community gero-psychiatric community services shall employ or have a written agreement with one or more psychiatrists with training and experience in gero-psychiatric services to serve as medical director. The duties of the medical director shall include, but are not limited to:

1. Responsibility for the overall medical and psychiatric care;

2. Advising the program director and the director of clinical services on medical/psychiatric issues, including the criteria for residents to be admitted, transferred or discharged;

3. Advising on the development, execution and coordination of policies and procedures that have a direct effect upon the quality of medical, nursing and psychiatric care delivered to residents; and

4. Acting as liaison and consulting with the administrator and the primary care physician on matters regarding medical, nursing and psychiatric care policies and procedures.

[~~12 VAC 35-105-1370.~~ 12 VAC 35-105-1340.] **Physician services and medical care.**

A. Each individual in a community gero-psychiatric residential service shall be under the care of a primary care physician. Nurse practitioners and physician assistants licensed to practice in Virginia may provide care in accordance with their practice agreements. Prior to, or at the time of admission, each individual, his legally authorized representative, or the entity responsible for his care shall designate a primary care physician.

B. The primary care physician shall conduct a physical examination at the time of admission or within [48 72] hours of admission into a community gero-psychiatric residential service. The primary care physician shall develop, in coordination with the interdisciplinary services planning team, a medical care plan of treatment for an individual.

C. All physicians or other prescribers shall review all medication orders at least every 60 days or whenever there is a change in medication.

D. The provider shall have a signed agreement with a local general hospital describing back-up and emergency medical care plans.

[~~12 VAC 35-105-1380.~~ 12 VAC 35-105-1350.] Pharmacy services for providers of community gero-psychiatric residential services.

A. The provider shall make provision for 24-hour emergency pharmacy services.

B. The provider shall have a written agreement with a qualified pharmacist to provide consultation on all aspects of the provision of pharmacy services and for regular visits, at least monthly.

C. A pharmacist licensed by the Virginia Board of Pharmacy shall review each individual's medication regimen. Any irregularities identified by the pharmacist shall be reported to the physician and the director of clinical services, and their response documented.

Article 7.

Intensive Community Treatment and Program of Assertive Community Treatment Services.

[~~12 VAC 35-105-1390.~~ 12 VAC 35-105-1360.] Admission and discharge criteria.

A. Individuals must meet the following admission criteria:

1. Severe and persistent mental illness, predominantly schizophrenia, other psychotic disorder, or bipolar disorder, that seriously impairs functioning in the community. Individuals with a sole diagnosis of substance addiction or abuse or mental retardation are not eligible for services.

2. [~~Significant functional impairments~~ Impairments] on a continuing or intermittent basis [without intensive community support] to include [one or more of the following]:

a. Inability to consistently perform practical daily living tasks required for basic adult functioning in the community;

b. Persistent or recurrent failure to perform daily living tasks except with significant support of assistance by family, friends or relatives;

c. Inability to be consistently employed at a self-sustaining level or inability to consistently carry out homemaker roles; or

d. Inability to maintain a safe living situation.

3. High service needs due to one or more of the following problems:

a. Residence in a state mental health facility or other psychiatric hospital but clinically assessed to be able to live in a more independent situation if intensive services were provided or anticipated to require extended

hospitalization [~~in a state mental health facility~~], if more intensive services are not available;

b. High user of state mental health facility or other acute psychiatric hospital inpatient services within the past two years or a frequent user of psychiatric emergency services (more than four times per year);

c. Intractable (i.e. persistent or very recurrent) severe major symptoms (e.g., affective, psychotic, suicidal);

d. Co-occurring substance addiction or abuse of significant duration (e.g., greater than six months);

e. High risk or a recent history (within the past six months) of criminal justice involvement (e.g., arrest and incarceration);

f. Unable to meet basic survival needs or residing in substandard housing, homeless, or at imminent risk of becoming homeless; or

g. Unable to consistently participate in traditional office-based services.

B. [~~Criteria for discharge are~~ PACT individuals should not be discharged for failure to comply with treatment plans or other expectations of the provider, except in certain circumstances as outlined. Individuals must meet at least one of the following criteria to be discharged]:

1. Moving out of the service area;

2. Death;

3. Incarceration for a period to exceed a year [or hospitalization for more than one year];

4. Choice of the individual (the provider is responsible for revising the individualized services plan to meet any concerns of the individual leading to the choice of discharge); or

5. Demonstration by the individual of an ability to function in all major role areas with minimal team contact and support for at least [~~one year~~ two years as determined by both the individual and ICT or PACT team].

[~~12 VAC 35-105-1400.~~ 12 VAC 35-105-1370.] Treatment team and staffing plan.

A. ICT and PACT Services are delivered by interdisciplinary teams.

1. The ICT team shall have employees or contractors [~~who are qualified to provide the services described in 12 VAC 35-105-1360, including at least five full-time equivalent clinical employees or contractors (80% of whom meet the qualifications of QMHP), a program assistant, and a full- or part-time psychiatrist~~], 80% of whom meet the qualifications of QMHP, who are qualified to provide the services described in 12 VAC 35-105-1410, including at least five full-time equivalent clinical employees or contractors on an ICT team and at least 10 full-time equivalent clinical employees or contractors on a PACT team, a program assistant, and a full- or part-time psychiatrist.] The team shall include the following positions:

Final Regulations

a. Team Leader – one full time equivalent (FTE) [~~LMHP~~ QMHP] with three years experience in the provision of mental health services to adults with serious mental illness.

b. Nurses – one or more FTE registered nurse with one year of experience or licensed practical nurse with three years of experience in the provision of mental health services to adults with serious mental illness.

c. Mental health professionals – two or more FTE QMHPs (half of whom shall hold a master's degree), including a vocational specialist and a substance abuse specialist.

d. Peer specialists – one or more FTE QPPMH or QMHP who is or has been a recipient of mental health services for severe and persistent mental illness.

e. Program assistant – one person with skills and abilities in medical records management, operating and coordinating the management information system, maintaining accounts and budget records for individual and program expenditures, and providing receptionist activities.

f. Psychiatrist – one board certified or board eligible in psychiatry and licensed to practice medicine. An equivalent ratio to 20 minutes (.008 FTE) of psychiatric time for each individual served must be maintained.

2. [~~PACT teams are ICT teams that consist of at least 10 full-time equivalent clinical employees or contractors in the same proportions including at least three FTE nurses. In addition, a PACT team includes at least three FTE nurses (at least one of whom is an RN and five or more mental health professionals.)~~]

B. ICT and PACT teams must include a minimum number of employees (counting contractors but not counting the psychiatrist and program assistant) to maintain an employee to individual ratio of at least 1:10. ICT teams may serve no more than 80 individuals. PACT teams may serve no more than 120 individuals. [A transition plan will be required of PACT teams that will allow for "start-up" when teams are not in full compliance with the PACT model relative to staffing patterns and client capacity.]

C. ICT and PACT teams shall meet daily Monday through Friday [or at least four days per week] to review and plan services and to plan for emergency and crisis situations.

D. ICT teams shall operate a minimum of 8 hours per day, [~~7 days per week, 365 days per year~~ 5 days per week] and shall provide services on a case-by-case basis in the evenings [and on weekends]. PACT teams shall be available to individuals 24 hours per day and shall operate a minimum of 12 hours each weekday and 8 hours each weekend day and each holiday.

E. The ICT and PACT team shall make crisis services directly available 24 hours a day but may [~~only~~] arrange coverage through another crisis services provider if the team coordinates with the crisis services provider daily. The PACT team shall operate an after-hours on-call system and be available to individuals by telephone or in person.

[~~12 VAC 35-105-1410.~~ 12 VAC 35-105-1380.] **Contacts.**

A. The ICT and PACT team shall have the capacity to provide multiple contacts per week to individuals experiencing severe symptoms or significant problems in daily living, for an aggregate average of three contacts per individual per week.

B. Each individual receiving ICT or PACT services shall be seen face-to-face by an employee or contractor [~~a minimum of at least one time per week and 75% of all such contacts should occur in vivo (i.e., in the community where people live, work, and recreate as opposed to any clinical office settings.)~~]; or the employee or contractor should attempt to make contact as specified in the ISP.]

[~~12 VAC 35-105-1420.~~ 12 VAC 35-105-1390.] **ICT [and PACT] service daily operation and progress notes.**

A. ICT teams and PACT teams shall conduct daily organizational meetings Monday through Friday at a regularly scheduled time to review the status of all individuals and the outcome of the most recent employee or contractor contact, assign daily and weekly tasks to employees and contractors, revise treatment plans as needed, plan for emergency and crisis situations, and to add service contacts that are identified as needed.

B. A daily log that provides a roster of individuals served in the ICT or PACT services program and documentation of services provided and contacts made with them shall be maintained. There shall also be at least a weekly individual note documenting progress or lack of progress toward goals and objectives as outlined in the Psychosocial Rehabilitation Services Plan.

[~~12 VAC 35-105-1430.~~ 12 VAC 35-105-1400.] **ICT and PACT assessment.**

The provider shall solicit the individual's own assessment of his needs, strengths, goals, preferences and abilities to identify the need for recovery oriented treatment, rehabilitation and support services and the status of his environmental supports within the individual's cultural context. The provider will assess:

1. Psychiatric history, mental status and diagnosis, including the content of an advance directive;
2. Medical, dental and other health needs;
3. Extent and effect of drug or alcohol use;
4. Education and employment including current daily structures use of time, school or work status, interests and preferences and the effect of psychiatric symptomatology on educational and employment performance;
5. Social development and functioning including childhood and family history, culture and religious beliefs leisure interests and social skills;
6. Housing and daily living skills, including the support needed to obtain and maintain decent, affordable housing integrated into the broader community; the current ability to meet basic needs such as personal hygiene, food preparation, housekeeping, shopping, money management

and the use of public transportation and other community based[~~accommodations~~ resources];

7. Family and social network including the current scope and strength of a individual's network of family, peers, friends, and co-workers and their understanding and expectations of the team's services;

8. Finances and benefits including the management of income, the need for and eligibility for benefits and the limitations and restrictions of those benefits; and

9. Legal and criminal justice involvement including the guardianship, commitment, representative payee status and the experience as either victim or accused person.

[~~12 VAC 35-105-1440.~~ 12 VAC 35-105-1410.] Service requirements.

Providers shall document that the following services are provided consistent with the individual's assessment and individualized services plan.

1. Ongoing assessment to ascertain the needs, strengths and preferences of the individual;
2. Case management;
3. Nursing;
4. Symptom assessment and management;
5. Psychopharmacological treatment, administration and monitoring;
6. Substance abuse assessment and treatment [~~including individual and group therapy~~]—for individuals with a dual diagnosis of mental illness and substance abuse;
7. Individual supportive therapy;
8. Skills training in activities of daily living, social skills, interpersonal relationships and leisure time;
9. Supportive [~~residential in-home~~] services;
10. Work-related services to help find and maintain employment;
11. Support for resuming education;
12. Support, education, consultation, and skill-teaching to family members and significant others;
13. Collaboration with families and assistance to individuals with children;
14. Direct support to help individuals obtain legal and advocacy services, financial support, money-management services, medical and dental services, transportation, and natural supports in the community;
15. Mobile crisis assessment, intervention and facilitation into and out of psychiatric hospitals.

[DOCUMENTS INCORPORATED BY REFERENCE

Diagnostic Criteria from the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, American Psychiatric Association, Washington, D.C., 1994.]

VA.R. Doc. Nos. R98-40, R01-103 and R01-104; Filed April 29, 2002, 1:29 p.m.



GENERAL NOTICES/ERRATA

STATE CORPORATION COMMISSION

Bureau of Insurance

AT RICHMOND, APRIL 24, 2002

COMMONWEALTH OF VIRGINIA

At the relation of the

STATE CORPORATION COMMISSION

CASE NO. INS-2002-00107

Ex Parte: In the matter of
Adopting Revisions to the Rules
Governing Settlement Agents

CORRECTING ORDER

In the Order to Take Notice entered herein April 16, 2002, in lines 8 through 10 on page 3 of the Order, there is a reference to "all title insurance companies, title insurance agents, and title insurance agencies licensed in the Commonwealth of Virginia." The correct reference, however, should be "all title insurance companies, title settlement agents, and title settlement agencies licensed in the Commonwealth of Virginia."

THEREFORE, IT IS ORDERED THAT:

(1) The reference in lines 8 through 10 on page 3 of the Order to Take Notice entered April 16, 2002, shall be corrected to read "all title insurance companies, title settlement agents, and title settlement agencies licensed in the Commonwealth of Virginia;" and

(2) All other provisions of the Order to Take Notice entered April 16, 2002, shall remain in full force and effect.

AN ATTESTED COPY hereof shall be sent by the Clerk of the Commission to the Bureau of Insurance in care of Deputy Commissioner Mary M. Bannister.

April 19, 2002

Administrative Letter 2002-4

TO: All Licensed Domestic Insurers

RE: USA Patriot Act of 2001

On October 26, 2001, President Bush signed into law the "Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism (USA PATRIOT) Act of 2001"¹ (the Act). This law, enacted in response to the terrorist attacks of September 11, 2001, strengthens our nation's ability to combat terrorism and prevent and detect money-laundering activities.

The purpose of this bulletin is to advise persons or entities regulated by the Bureau of Insurance of important new responsibilities under the Act. In particular, Section 352 of the Act amends the Bank Secrecy Act ("BSA")² to require that all financial institutions establish an anti-money laundering program, and Section 326 amends the BSA to require the Secretary of the Treasury (Treasury) to adopt minimum standards for financial institutions regarding the identity of customers that open accounts.

Section 352 – Establishing Anti-Money Laundering Programs

Section 352 of the Act requires the establishment of an anti-money laundering program, including, at a minimum:

- The development of internal policies, procedures, and controls; these should be appropriate for the level of risk of money laundering identified.
- The designation of a compliance officer; the officer should have appropriate training and background to execute their responsibilities. In addition, the compliance officer should have access to senior management.
- An ongoing employee training program; a training program should match training to the employees' roles in the organization and their job functions. The training program should be provided as often as necessary to address gaps created by movement of employees within the organization and turnover.
- An independent audit function to test the programs. The independent audit function does not require engaging outside consultants. Internal staff that is independent of those developing and executing the anti-money laundering program may conduct the audit.

Treasury is currently drafting a regulation describing the anti-money laundering compliance program for insurers. The regulation may borrow from the anti-money laundering compliance program rule recently proposed by the NASD for broker-dealers,³ and is expected to be promulgated in late spring or early summer.

Insurance companies are included in the BSA's definition of financial institution, and should be prepared to comply with the new law and the regulations promulgated thereunder. Section 352 of the Act becomes effective on April 24, 2002; all insurance companies are required to be in compliance with the law by that date.

As part of its rulemaking process, Treasury is determining the extent to which other insurance entities will be considered financial institutions for purposes of the regulation. It is anticipated that the regulation could cover all other persons and entities engaged in the business of insurance, including brokers, agents, and managing general agents, and may also include other regulated entities. These insurance entities will

¹ The full text of the law can be obtained at www.access.gpo.gov/congress. Scroll to public and private laws, select 107th Congress, and select Public Law 107-56.

² Codified in subchapter II of chapter 53 of Title 31, U.S. Code.

³ 67CFR 8565 (February 25, 2002)

be required to comply with the regulation by the regulation's effective date.

Anti-money laundering programs are not anticipated to be "one size fits all." Rather, it is expected that they will be developed using a risk-based approach. Development of an anti-money laundering program should begin with identification of those areas, processes and programs that are susceptible to money laundering activities. The practices and procedures implemented under the program should reflect the risks of money laundering given the entity's products, methods of distribution, contact with customers and forms of customer payment and deposits.

Section 326 – Customer Identification

Section 326 of the Act amends the BSA to require that Treasury issue regulations setting forth minimum standards for financial institutions regarding the identity of their customers in connection with the purchase of a policy or contract of insurance. This program must set forth customer identity verification and documentation procedures, as well as procedures the insurer will employ to notify its customers about this requirement and determine whether the customer appears on government lists of known or suspected terrorists or terrorist organizations.

Final regulations regarding this requirement are to be issued by the Department of the Treasury by October 26, 2002. Proposed regulations will be published in the Federal Register⁴ later in the year. Through the rulemaking process, Treasury will determine which insurance entities will be subject to the regulations. Insurance entities subject to the rules will be required to comply when the final Treasury regulations become effective.

Requests for additional information or questions regarding:

- this bulletin may be directed to Donald C. Beatty at (804) 371-9115 or via email at dbeatty@scc.state.va.us.
- the Act may be directed to Linda L. Duzick, Office of Thrift Supervision, serving as insurance industry liaison for the Department of the Treasury, at (202) 906-6565 or linda.duzick@ots.treas.gov.

/s/ Alfred W. Gross
Commissioner of Insurance

STATE BOARD OF HEALTH AND DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Notice of Request for Certificate of Public Need Applications for Development of Additional Nursing Home Beds

Legal Notice of Request for Certificate of Public Need Applications.

Pursuant to the authority vested in the State Board of Health (Board) and the Department of Medical Assistance Services (DMAS) by § 32.1-102.3:2 of the Code of Virginia, notice is hereby given of the issuance of a proposed Request for Applications (RFA). This RFA is a request for certificate of public need (COPN) applications for projects that will result in an increase in the number of beds in which nursing home services are provided in the Commonwealth of Virginia. The RFA process is outlined in 12 VAC 5-220-335 of the Virginia Medical Care Facilities Certificate of Public Need Rules and Regulations.

Eligible Planning Districts and Total Nursing Home Beds Available for Authorization.

In the review cycle established by this RFA, the commissioner will consider requests for COPNs that propose an increase in nursing home beds in the following planning districts ("PD") and that propose an increase no greater than the number of available beds shown below for each planning district. COPN requests that propose an increase in nursing home beds in any other planning districts, not identified below, or propose an increase in beds greater than the number of available beds shown below for each planning district will not be accepted for review.

- Planning District 11, also known as Central Virginia Planning District, consisting of the counties of Amherst, Appomattox, Bedford, and Campbell and the cities of Bedford and Lynchburg.

Total nursing home beds available for authorization: 60.

- Planning District 13, also known as Southside Planning District, consisting of the counties of Brunswick, Halifax, and Mecklenburg.

Total nursing home beds available for authorization: 120.

Basis for the Request for Applications.

Planning District 11. Senate Bill 490 (Chapter 168, Acts of the Assembly), approved March 22, 2002, directs the Commissioner of Health to reissue an RFA for 60 new nursing home beds in Planning District 11, because a previously issued COPN for 60 nursing home beds in PD 11 was surrendered by the applicant that had received it. The commissioner may issue one or more COPNs for an increase of such 60 new nursing home beds to existing facilities within PD 11.

The commissioner will give preference in issuing any COPN for these 60 beds to facilities located in a rapid-growth area of PD 11.

⁴ The Federal Register website address is www.access.gpo.gov/nara.

General Notices/Errata

Planning District 13. Senate Bill 490 (Chapter 168, Acts of the Assembly), approved March 22, 2002, directs the Commissioner of Health to reissue an RFA for 120 new nursing home beds in Planning District 13 because a previously issued COPN for 120 nursing home beds in PD 13 expired before construction of the facility started. The commissioner may issue one or more COPNs for an increase of such 120 new nursing home beds to existing or proposed new facilities within PD 13.

Basis for Review.

The commissioner, in his review of COPN requests submitted pursuant to this RFA, will consider each of the twenty factors enumerated at § 32.1-102.3 B of the Code of Virginia, as applicable. He will also consider applicable standards of the State Medical Facilities Plan (12 VAC 5-360).

Projection of Potential Fiscal Impact.

The Department of Medical Assistance Services projects total additional expenditures for medical services provided to Medicaid recipients of approximately \$3.98 million for the fiscal year ending June 30, 2004, if all the beds included in this RFA are authorized and available for occupancy by June 30, 2003. This projection is based on the following key assumptions:

| | |
|--|----------|
| Average proportion of beds filled during FY 2004 | 90% |
| Assumed Medicaid proportion of bed-days of service | 67% |
| Average estimated payment rate per day (direct, indirect, and capital costs) | \$100.43 |
| Estimated patient-pay portion (patient pay not included above) | not app. |

Schedule for Review.

A schedule for review of the COPN requests filed in response to the final RFA will be included in the final RFA and will be in conformance with the provisions of 12 VAC 5-220-355.

Application Fees.

The Virginia Department of Health shall collect fees for COPN applications filed in response to this RFA. No application may be deemed to be complete for review until the required application fee is paid. The fee is one percent of the proposed capital expenditure for the project, but not less than \$1,000 or more than \$20,000.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Notice of Intent to Reduce Costs Related to NF Indirect Care Costs and Continue the PIRS NF Reimbursement Methodology Pending the Implementation of the RUGs NF Reimbursement Methodology

Notice is hereby given that the Department of Medical Assistance Services (DMAS) intends to modify its reimbursement plan for enrolled nursing facilities pursuant to

the department's authority under Title XIX of the Social Security Act. This notice is intended to satisfy the requirements of 42 CFR 447.205 and of § 1902(a)(13) of the Social Security Act, 42 USC § 1396a(a)(13). All of the changes contained in this public notice are occurring in response to mandates of the 2002 General Assembly as contained in 2002 House Bill 30, Item 325 HH 1 and 2 and 325 MM. The two NF payment changes contained in item 325 HH 1 and 2 are expected to result in a net reduction of reimbursement of \$12 M. The PIRS methodology change is intended to be budget neutral.

Reduction of NF Indirect Care Cost Ceiling

Currently the indirect patient care operating ceiling is set at 106.9% of the median of facility-specific indirect cost per day. The calculation of the median is based on cost reports from freestanding nursing homes for provider fiscal years ending in calendar year 1998. In accordance with the State Plan, DMAS revises its ceilings every two years. The budget bill provided funding that mandated an adjustment in the indirect patient care operating cost ceiling. When the indirect ceiling is revised July 1, 2002, based on data from cost reporting periods ending calendar year 2000, the indirect ceiling will be set at 103.9% instead of 106.9%. This will result in a lower indirect ceiling than otherwise would have been established for state fiscal years 2003 and 2004.

Elimination of NF Indirect Care Cost Inflation Factor

Nursing facilities currently have their prospective operating cost ceilings (direct and indirect) and prospective operating cost rates adjusted for inflation in accordance with 12 VAC 30-90-41. The allowance for inflation is based on the percentage of change in the moving average of the skilled nursing facility market basket of routine service costs as developed by Data Resources, Incorporated (DRI), adjusted for Virginia, determined in the quarter in which the nursing facility's most recent fiscal year ended. The budget directed that the Department of Medical Assistance Services shall amend the State Plan for Medical Assistance Services to eliminate the increase for inflation to indirect patient care rates in SFY 2003. No changes are made in reimbursement for direct patient care.

Retention of PIRS Reimbursement Methodology Pending RUGs Methodology Adoption

In the event that the Resource Utilization Groups methodology does not become operative on July 1, 2002, DMAS shall have the authority, pursuant to § 1919(b) through (d) of the Social Security Act, to use the last score to calculate rates which will be needed to establish rates under the current PIRS reimbursement methodology.

Data will be collected for payment purposes prescribed by DMAS on the new DMAS-80 (maf revised 2/02) form at the time of admission and then twice a year for every Medicaid recipient in a nursing facility (NF). The NFs Service Intensity Index (SII), derived from the most recently recorded DMAS-80 assessment data submission will be retained and used for all NFs in the Commonwealth according to 12 VAC 30-90-300.

The normalized SII shall be used to calculate the direct patient care operating cost prospective ceilings and direct patient

care operating cost prospective rates for each semiannual period of a NFs subsequent fiscal years according to and illustrated in 12 VAC 30-90-300.

A copy of this notice is available for public review from N. Stanley Fields, Director, Division of Cost Settlement and Audit, Department of Medical Assistance Services, 600 Broad Street, Suite 1300, Richmond, VA 23219, and this notice is available for public review at any local social service office. Addresses for local social service offices may be obtained by contacting Mr. Fields or the local city or county government. Comments or inquiries may be submitted in writing within 30 days of this notice publication to Mr. Fields, and such comments are available for review at the same address.

DEPARTMENT OF SOCIAL SERVICES

Periodic Review of Regulations

Pursuant to Executive Order Number Twenty-five (98), the Department of Social Services is currently reviewing the regulation 22 VAC 40-11, Public Participation Guidelines, to determine if it should be terminated, amended, or retained in its current form. The review will be guided by the principles listed in Executive Order Number Twenty-five (98) and in the department's Plan for Review of Existing Agency Regulations.

The department seeks public comment regarding the regulation's interference in private enterprise and life, essential need of the regulation, less burdensome and intrusive alternatives to the regulation, specific and measurable goals that the regulation is intended to achieve, and whether the regulation is clearly written and easily understandable.

Written comments may be submitted until June 9, 2002, in care of Richard Martin, Regulatory Coordinator, Department of Social Services, 730 East Broad Street, Richmond, VA 23219-1849, by facsimile to (804) 692-1814, or by e-mail to lrm2@dss.state.va.us.

Periodic Review of Regulations

Pursuant to Executive Order Number Twenty-five (98), the Department of Social Services is currently reviewing the regulation 22 VAC 40-670, Degree Requirement for Social Work/Social Work Supervisor Classification, to determine if it should be terminated, amended, or retained in its current form. The review will be guided by the principles listed in Executive Order Number Twenty-five (98) and in the department's Plan for Review of Existing Agency Regulations.

The department seeks public comment regarding the regulation's interference in private enterprise and life, essential need of the regulation, less burdensome and intrusive alternatives to the regulation, specific and measurable goals that the regulation is intended to achieve, and whether the regulation is clearly written and easily understandable.

Written comments may be submitted until June 9, 2002, in care of Lori A. Kam, Human Resource Manager, Department of Social Services, 730 East Broad Street, Richmond, VA

23219-1849, by facsimile to (804) 692-1560, or by e-mail to lak900@dss.state.va.us.

VIRGINIA CODE COMMISSION

Notice to State Agencies

Mailing Address: Virginia Code Commission, 910 Capitol Street, General Assembly Building, 2nd Floor, Richmond, VA 23219, FAX (804) 692-0625.

Forms for Filing Material for Publication in *The Virginia Register of Regulations*

All agencies are required to use the appropriate forms when furnishing material for publication in the Virginia Register of Regulations. The forms may be obtained from: Virginia Code Commission, 910 Capitol Street, General Assembly Building, 2nd Floor, Richmond, VA 23219, telephone (804) 786-3591.

Internet: Forms and other Virginia Register resources may be printed or downloaded from the Virginia Register web page: <http://legis.state.va.us/codecomm/register/regindex.htm>

FORMS:

NOTICE of INTENDED REGULATORY ACTION - RR01
NOTICE of COMMENT PERIOD - RR02
PROPOSED (Transmittal Sheet) - RR03
FINAL (Transmittal Sheet) - RR04
EMERGENCY (Transmittal Sheet) - RR05
NOTICE of MEETING - RR06
AGENCY RESPONSE TO LEGISLATIVE OBJECTIONS - RR08

ERRATA

STATE BOARD OF HEALTH

Title of Regulation: **12 VAC 5-520. Regulations Governing the Dental Scholarship and Loan Replacement Programs.**

Publication: 18:15 VA.R. 1969 April 8, 2002

Correction to Final Regulation:

12 VAC 5-520-30, strike "the effective date of these regulations" and insert "May 8, 2002,"

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Title of Regulation: **12 VAC 30-141. Family Access to Medical Insurance Security Plan.**

Publication: 17:25 VA.R. 3660-3670 August 27, 2001.

Correction to Emergency Regulation:

Page 3664, 12 VAC 30-141-90 F, change "12 VAC 30-110-1300" to "subdivisions 3 b and c of 12 VAC 30-40-10"

General Notices/Errata

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Title of Regulation: **12 VAC 30-150. Uninsured Medical Catastrophe Fund.**

Publication: 18:17 VA.R. 2174 May 6, 2002.



Correction to Final Regulation:

Replace Registrar's Notice with the following notice:

| |
|---|
| REGISTRAR'S NOTICE: The proposed regulation was adopted as published in 18:2 VA.R. 166-172 October 8, 2001, without change. Therefore, pursuant to § 2.2-4031 of the Code of Virginia, the text of the final regulation is not set out. |
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CALENDAR OF EVENTS

Symbol Key

-  Location accessible to persons with disabilities
 Teletype (TTY)/Voice Designation

NOTICE


Only those meetings which are filed with the Registrar of Regulations by the filing deadline noted at the beginning of this publication are listed. Since some meetings are called on short notice, please be aware that this listing of meetings may be incomplete. Also, all meetings are subject to cancellation and the *Virginia Register* deadline may preclude a notice of such cancellation. If you are unable to find a meeting notice for an organization in which you are interested, please check the Commonwealth Calendar at www.vipnet.org or contact the organization directly.

For additional information on open meetings and public hearings held by the standing committees of the legislature during the interim, please call Legislative Information at (804) 698-1500 or Senate Information and Constituent Services at (804) 698-7410 or (804) 698-7419/TTY , or visit the General Assembly web site's Legislative Information System (<http://leg1.state.va.us/lis.htm>) and select "Meetings."


VIRGINIA CODE COMMISSION

EXECUTIVE


BOARD OF ACCOUNTANCY

† **June 5, 2002 - 9 a.m.** -- Open Meeting
Virginia Department of Transportation, Procurement Building,
87 Deacon Road, Fredericksburg, Virginia.  (Interpreter for
the deaf provided upon request)

A meeting of the Enforcement Committee to review pending
complaints and compliance policy. Public comment will not
be received.


Contact: Nancy Taylor Feldman, Executive Director, Board of
Accountancy, 3600 W. Broad St., Suite 696, Richmond, VA
23230-4916, telephone (804) 367-8505, FAX (804) 367-2174,
(804) 367-9753/TTY , e-mail boa@boa.state.va.us.

DEPARTMENT OF AGRICULTURE AND CONSUMER SERVICES


May 21, 2002 - 9:30 a.m. -- Open Meeting
Department of Agriculture and Consumer Services, 1100
Bank Street, Washington Building, 2nd Floor Board Room,
Richmond, Virginia.  (Interpreter for the deaf provided upon
request)

The Consumer Affairs Advisory Committee communicates
the views and interests of Virginians on issues related to the
Department of Agriculture and Consumer Services' consumer
education and fraud prevention programs and
their availability to citizens. Members will review the
consumer education outreach efforts for the past six months
and assist with planning for events in 2002. Members will
entertain public comment at the conclusion of all other
business for a period not to exceed 30 minutes. Any person
who needs any accommodation in order to participate at the
meeting should contact Evelyn A. Jez at least five days
before the meeting date so that suitable arrangements can
be made.

Contact: Evelyn A. Jez, Consumer Affairs Specialist,
Department of Agriculture and Consumer Services, 1100

Bank St., Suite 1101, Richmond, VA 23219, telephone (804)
786-1308, FAX (804) 786-5112, toll-free (800) 552-9963,
(800) 828-1120/TTY 


Virginia State Apple Board

† **June 19, 2002 - 1 p.m.** -- Open Meeting
Rowe's Restaurant, 74 Rowe Road (intersection of I-81/Route
250), Staunton, Virginia. 

The board will meet to approve the minutes of the last
meeting. In addition, the board will review its financial
statement. The board is expected to discuss old business
arising from the last board meeting and any new business
to come before the board. The board will entertain public
comment at the conclusion of all other business for a period
not to exceed 30 minutes. Any person who needs any
accommodation in order to participate at the meeting should
contact Dave Robishaw at least five days before the
meeting date so that suitable arrangements can be made.

Contact: Dave Robishaw, Secretary, Department of
Agriculture and Consumer Services, 900 Natural Resources
Dr., Suite 300, Charlottesville, VA 22903, telephone (434)
984-0573, FAX (434) 984-4156.

Farmland Preservation Task Force

† **May 21, 2002 - 10 a.m.** -- Open Meeting
20850 Oatlands Plantation Lane, Leesburg, Virginia. 


The VDACS Farmland Preservation Task Force has the
responsibility of developing a proposed Purchase of
Development Rights (PDR) Program for the state and at this
session the Task Force will begin to review the experiences
of other states with PDR programs and develop a vision for
farmland preservation in Virginia. The Task Force plans to
have a draft proposal ready for public comment in the fall of
2002. Any person who needs any accommodation in order
to participate at the meeting should contact William P.
Dickinson, Jr. at least five days before the meeting date so
that suitable arrangements can be made.

Contact: William P. Dickinson, Jr., Assistant Commissioner,
Department of Agriculture and Consumer Services, P.O. Box

Calendar of Events

1163, Richmond, VA 23218, telephone (804) 786-3502, FAX (804) 371-2945, toll-free (800) 828-1120, e-mail wdickinson@vdacs.state.va.us.

STATE AIR POLLUTION CONTROL BOARD


† **May 21, 2002 - 10 a.m.** -- Open Meeting
General Assembly Building, 9th and Broad Streets, House Room C, Richmond, Virginia. 

A regular meeting.

Contact: Cindy Berndt, Regulatory Coordinator, Department of Environmental Quality, P.O. Box 10009, Richmond, VA 23240, telephone (804) 698-4378, FAX (804) 698-4346, e-mail cmberndt@deq.state.va.us.


† **May 28, 2002 - 7 p.m.** -- Open Meeting
Pittsylvania County Vocational-Technical Education Center, Route 29, 4 miles south of Chatham, Virginia. 

A public briefing to describe White Oak Power Company, LLC's proposed 680 megawatt simple cycle power plant to be located in Pittsylvania County.


Contact: William S. Shenk, State Air Pollution Control Board, 7705 Timberlake Rd., Lynchburg, VA 24502, telephone (434) 582-5120, (804) 698-4021/TTY , e-mail wsshensk@deq.state.va.us.

† **June 27, 2002 - 7 p.m.** -- Public Hearing
Pittsylvania County Vocational-Technical Education Center, Route 29, 4 miles south of Chatham, Virginia. 


A public hearing to receive comments on the proposed draft permit for White Oak Power Company, LLC's proposed 680 megawatt simple cycle power plant to be located in Pittsylvania County.

Contact: William S. Shenk, State Air Pollution Control Board, 7705 Timberlake Rd., Lynchburg, VA 24502, telephone (434) 582-5120, (804) 698-4021/TTY , e-mail wsshensk@deq.state.va.us.


ALZHEIMER'S DISEASE AND RELATED DISORDERS COMMISSION

May 21, 2002 - Noon -- Open Meeting
National Capital Chapter of the Alzheimer's Association, 11240 Waples Mill Road, Fairfax, Virginia.  (Interpreter for the deaf provided upon request)


A regular meeting.

Contact: Janet L. Honeycutt, Director of Grant Operations, Alzheimer's Disease and Related Disorders Commission, 1600 Forest Ave., Suite 102, Richmond, VA 23229, telephone (804) 662-9341, FAX (804) 662-9354, toll-free (800) 552-3402, (804) 662-9333/TTY , e-mail jlhoneycutt@vdh.state.va.us.

BOARD FOR ARCHITECTS, PROFESSIONAL ENGINEERS, LAND SURVEYORS, CERTIFIED INTERIOR DESIGNERS AND LANDSCAPE ARCHITECTS

June 6, 2002 - 9 a.m. -- Open Meeting
Department of Professional and Occupational Regulation, 3600 West Broad Street, Richmond, Virginia.  (Interpreter for the deaf provided upon request)

A meeting to conduct general business of the board. Persons desiring to participate in the meeting and requiring special accommodations or interpreter services should contact the department at least 10 days prior to the meeting so that suitable arrangements can be made. The department fully complies with the Americans with Disabilities Act.

Contact: Mark N. Courtney, Assistant Director, Department of Professional and Occupational Regulation, 3600 W. Broad St., Richmond, VA 23230-4917, telephone (804) 367-8514, FAX (804) 367-2475, (804) 367-9753/TTY , e-mail apelsla@dpor.state.va.us.


ART AND ARCHITECTURAL REVIEW BOARD

NOTE: CHANGE IN MEETING LOCATION


June 7, 2002 - 10 a.m. -- Open Meeting

July 12, 2002 - 10 a.m. -- Open Meeting


August 2, 2002 - 10 a.m. -- Open Meeting

Virginia War Memorial, 601 South Belvidere Street, Richmond, Virginia.  (Interpreter for the deaf provided upon request)

A monthly meeting to review projects submitted by state agencies. AARB submittal forms and submittal instructions can be downloaded by visiting the DGS forms center at www.dgs.state.va.us. Request submittal form DGS-30-905 or submittal instructions form DGS-30-906.

Contact: Richard L. Ford, AIA, Chairman, Art and Architectural Review Board, 1011 E. Main St., Room 221, Richmond, VA 23219, telephone (804) 643-1977, FAX (804) 643-1981, (804) 786-6152/TTY 

VIRGINIA BOARD FOR ASBESTOS, LEAD, AND HOME INSPECTORS

† **May 21, 2002 - 10 a.m.** -- Open Meeting
Department of Professional and Occupational Regulation, 3600 West Broad Street, Conference Room 5E, Richmond, Virginia. 

A meeting to discuss and develop test specifications to be considered by the board while selecting a certification examination for home inspectors.

Contact: David Dick, Assistant Director, Department of Professional and Occupational Regulation, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-2648, FAX (804) 367-6128, (804) 367-9753/TTY , e-mail asbestos@dpor.state.va.us.

July 16, 2002 - 10 a.m. -- Open Meeting

Department of Professional and Occupational Regulation,
3600 West Broad Street, Conference Room 5W, Richmond,
Virginia.

A meeting to conduct routine business. A public comment period will be held at the beginning of the meeting.

Contact: David Dick, Assistant Director, Department of Professional and Occupational Regulation, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-2648, FAX (804) 367-6128, (804) 367-9753/TTY , e-mail asbestos@dpor.state.va.us.

ASSISTIVE TECHNOLOGY LOAN FUND AUTHORITY**† June 20, 2002 - 10 a.m. -- Open Meeting**

Department of Rehabilitative Services, Ratcliffe Building, 8004 Franklin Farms Drive, Richmond, Virginia. (Interpreter for the deaf provided upon request)

A meeting of the Board of Directors. The public is welcome and will have an opportunity to address the board. Following the business meeting, the board will meet in executive session to review loan applications for assistive technology.

Contact: Shilpa Joshi, Assistive Technology Loan Fund Authority, P.O. Box K091, Richmond, VA 23288, telephone (804) 662-9000, FAX (804) 662-9533, toll-free (800) 552-5019, (804) 662-9000/TTY , e-mail loanfund@erols.com.

**DEPARTMENT FOR THE BLIND AND VISION
IMPAIRED****Statewide Rehabilitation Council for the Blind****June 8, 2002 - 10 a.m. -- Open Meeting**

Administrative Headquarters, 397 Azalea Avenue, Richmond, Virginia. (Interpreter for the deaf provided upon request)

The council meets quarterly to advise the Department for the Blind and Vision Impaired on matters related to vocational rehabilitation services for the blind and visually impaired citizens of the Commonwealth.

Contact: James G. Taylor, Vocational Rehabilitation Program Director, Department for the Blind and Vision Impaired, 397 Azalea Ave., Richmond, VA 23227, telephone (804) 371-3111, FAX (804) 371-3390, toll-free (800) 622-2155, (804) 371-3140/TTY , e-mail taylorjg@dbvi.state.va.us.

CHARITABLE GAMING COMMISSION**May 22, 2002 - 10 a.m. -- Open Meeting**

General Assembly Building, 9th and Broad Streets, House Room C, Richmond, Virginia.

A regular commission meeting. The agenda will be posted on the agency's web site at <http://www.state.va.us/cgchome>.

Contact: Frances C. Jones, Administrative Staff Assistant, Charitable Gaming Commission, James Monroe Bldg., 101 N.

14th St., 17th Floor, Richmond, VA 23219, telephone (804) 786-3014, FAX (804) 786-1079, e-mail jones@cgc.state.va.us.

COMPENSATION BOARD**May 28, 2002 - 11 a.m. -- Open Meeting****† June 25, 2002 - 11 a.m. -- Open Meeting**

Compensation Board, 202 North 9th Street, 10th Floor, Richmond, Virginia.

A monthly board meeting.

Contact: Cindy P. Waddell, Administrative Staff Assistant, Compensation Board, P.O. Box 710, Richmond, VA 23218, telephone (804) 786-0786, FAX (804) 371-0235, e-mail cwaddell@scb.state.va.us.

**DEPARTMENT OF CONSERVATION AND
RECREATION****May 23, 2002 - 9 a.m. -- Open Meeting****NOTE: CHANGE IN MEETING LOCATION**

Mason Neck State Park, Visitor's Center, 7301 High Point Road, Lorton, Virginia. (Interpreter for the deaf provided upon request)

The second meeting of the Mason Neck State Technical Advisory Committee in preparation of a new Mason Neck State Park Master Plan. Requests for interpreter services for the deaf should be filed two weeks prior to the meeting.

Contact: John R. Davy, Director of Planning and Recreation Resources, Department of Conservation and Recreation, 203 Governor St., Suite 326, Richmond, VA 23219, telephone (804) 786-1119, FAX (804) 371-7899, e-mail jdavy@dcrr.state.va.us.

† May 30, 2002 - 7 p.m. -- Open Meeting

Emmanuel Episcopal - Delaplane Church, 9668 Maidstone Drive, Delaplane, Virginia. (Interpreter for the deaf provided upon request)

The Sky Meadows State Park Technical Advisory Committee will explain the state park master planning process will be explained, and public input will be received on the draft park mission statement and draft goals and objectives.

Contact: Derral Jones, Planning Bureau Manager, Department of Conservation and Recreation, 203 Governor St., Suite 326, Richmond, VA 23219, telephone (804) 786-9042, FAX (804) 371-7899, e-mail djones@dcrr.state.va.us.

June 12, 2002 - 9 a.m. -- Open Meeting


Cumberland Central Bank, 1422 Anderson Highway, Cumberland, Virginia. (Interpreter for the deaf provided upon request)

A regular meeting of the Bear Creek Lake Park Technical Committee regarding the park's master plan.

Contact: Jim Guyton, Environmental Program Manager, Department of Conservation and Recreation, 203 Governor

Calendar of Events


St., Suite 326, Richmond, VA 23219, telephone (804) 786-2093, FAX (804) 371-7899, e-mail jguyton@dc.state.va.us.

June 13, 2002 - 7 p.m. -- Open Meeting
Gunston Hall, 10709 Gunston Road, Mason Neck, Virginia. 
(Interpreter for the deaf provided upon request)

The Mason Neck State Park Technical Advisory Committee will explain the state park master planning process. Public input will be received on the draft park mission statement and draft goals and objectives.

Contact: John R. Davy, Director, Division of Planning and Recreation Resources, Department of Conservation and Recreation, 203 Governor St., Suite 326, Richmond, VA 23219, telephone (804) 786-1119, FAX (804) 371-7899, e-mail jdavy@dc.state.va.us.


Virginia Cave Board

† June 1, 2002 - 1 p.m. -- Open Meeting
Virginia Commonwealth University, Trani Life Science Building, 1000 West Cary Street, 1st Floor Conference Room, Richmond, Virginia.  (Interpreter for the deaf provided upon request)

A regular business meeting. Committee meetings begin at 11 a.m.; the full board meets at 1 p.m. Participants should contact DCR in advance of the meeting by calling 804-786-7951 so that a list of attendees can be given to VCU security.

Contact: Larry Smith, Natural Area Protection Manager, Department of Conservation and Recreation, 203 Governor St., Richmond, VA 23219, telephone (804) 371-6205, FAX (804) 786-6141, e-mail lsmith@dc.state.va.us.


Falls of the James Scenic River Advisory Board

June 6, 2002 - Noon -- Open Meeting
† July 11, 2002 - Noon -- Open Meeting
Richmond City Hall, 900 East Broad Street, Planning Commission Conference Room, 5th Floor, Richmond, Virginia.  (Interpreter for the deaf provided upon request)

A meeting to discuss river issues.

Contact: Richard G. Gibbons, Environmental Program Manager, Department of Conservation and Recreation, 203 Governor St., Suite 326, Richmond, VA 23219, telephone (804) 786-4132, FAX (804) 371-7899, e-mail rgibbons@dc.state.va.us.

BOARD FOR CONTRACTORS

† June 5, 2002 - 9 a.m. -- Open Meeting
Department of Professional and Occupational Regulation, 3600 West Broad Street, 4th Floor, Richmond, Virginia. 
(Interpreter for the deaf provided upon request)

A regularly scheduled meeting to address policy and procedural issues, review and render case decisions on matured complaints against licensees, and address other matters that may require board action. The meeting is open to the public; however, a portion of the board's business

may be discussed in closed meeting. The department fully complies with the Americans for Disabilities Act. Persons desiring to participate in the meeting and requiring special accommodations or interpreter services should contact Eric L. Olson.


Contact: Eric L. Olson, Assistant Director, Department of Professional and Occupational Regulation, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-2785, FAX (804) 367-2474, (804) 367-9753/TTY , e-mail contractors@dpor.state.va.us.


BOARD OF COUNSELING

Credentials Committee


† May 30, 2002 - 3 p.m. -- Open Meeting
† May 31, 2002 - 10:30 a.m. -- Open Meeting
Department of Health Professions, 6606 West Broad Street, 5th Floor, Richmond, Virginia 


A meeting to review applicant credentials.

Contact: Joyce D. Williams, Administrative Assistant, Board of Counseling, 6606 W. Broad St., 4th Floor, Richmond, VA 23230, telephone (804) 662-9912, FAX (804) 662-7250, (804) 662-7197/TTY , e-mail coun@dhp.state.va.us.


† May 30, 2002 - 10:30 a.m. -- Open Meeting
† May 31, 2002 - 10:30 a.m. -- Open Meeting
Department of Health Professions, 6606 West Broad Street, 5th Floor, Conference Room 2, Richmond, Virginia 

The board will hear remarks from the director and discuss regulatory actions, continuing education, supervision, and the board website. The meeting will be recessed at approximately noon and reconvened at 10:30 a.m. on May 31.

Contact: Evelyn B. Brown, Executive Director, Board of Counseling, Southern States Bldg., 6606 W. Broad St., 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9912, FAX (804) 662-9943, (804) 662-7197/TTY , e-mail ebrown@dhp.state.va.us.

† May 31, 2002 - 10:30 a.m. -- Open Meeting
Department of Health Professions, 6606 West Broad Street, 5th Floor, Conference Room 2, Richmond, Virginia 

The board will consider reports of standing committees and work groups. The board will also take regulatory action on the Certification of Substance Abuse Counselor Assistant proposed regulations. Public comment will be heard at the beginning of the meeting.

Contact: Evelyn B. Brown, Executive Director, Board of Counseling, Southern States Bldg., 6606 W. Broad St., 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9912, FAX (804) 662-9943, (804) 662-7197/TTY , e-mail ebrown@dhp.state.va.us.

Regulatory/Supervision/Legislative Committee

† **May 31, 2002 - 9 a.m.** -- Open Meeting
Department of Health Professions, 6606 West Broad Street,
5th Floor, Conference Room 2, Richmond, Virginia ☎

A meeting of the Regulatory/Supervision/Legislative Committee to discuss regulatory actions including, but not limited to certification of substance abuse counselor assistants. Public comment will be received at the beginning of the meeting.

Contact: Evelyn B. Brown, Executive Director, Board of Counseling, Southern States Bldg., 6606 W. Broad St., 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9912, FAX (804) 662-9943, (804) 662-7197/TTY ☎, e-mail ebrown@dhp.state.va.us.

* * * * *

† **May 31, 2002 - 1:30 p.m.** -- Public Hearing
Department of Health Professions, 6606 West Broad Street,
5th Floor, Conference Room 2, Richmond, Virginia ☎

July 19, 2002 - Public comments may be submitted until this date.

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Board of Counseling is amending regulations entitled: **18 VAC 115-60. Regulations Governing the Practice of Licensed Substance Abuse Treatment Practitioners.** The purpose of the proposed action is to adopt a one-year waiver of the licensure requirements in the current regulations for individuals who hold certain combinations of education and work experience in substance abuse.

Statutory Authority: §§ 54.1-2400 and 54.1-3508 of the Code of Virginia.

Public comments may be submitted until July 19, 2002, to Evelyn B. Brown, Executive Director, Board of Counseling, 6606 W. Broad St., Richmond, VA 23230.

Contact: Elaine J. Yeatts, Regulatory Coordinator, Department of Health Professions, 6606 W. Broad St., Richmond, VA 23230, telephone (804) 662-9918, FAX (804) 662-9114 or e-mail elaine.yeatts@dhp.state.va.us.

DEPARTMENT FOR THE DEAF AND HARD-OF-HEARING

† **June 18, 2002 - 10 a.m.** -- Open Meeting
Northern Virginia Resource Center for Deaf and Hard of Hearing Persons, 10359 Democracy Lane, Fairfax, Virginia ☎
(Interpreter for the deaf provided upon request)

A regular meeting of the Virginia Relay Advisory Council. The council will review and discuss the draft Request for Proposals for marketing services. Council will recommend final changes for the RFP.

Contact: Sandra Bocclair, Council Liaison, Department for the Deaf and Hard-of-Hearing, 1602 Rolling Hills Dr., Suite 203, telephone (804) 662-9789, FAX (804) 662-9718, toll-free (800)

552-7917, (804) 662-9502/TTY ☎, e-mail boclaiss@ddhh.state.va.us.

BOARD OF DENTISTRY

May 31, 2002 - 9 a.m. -- Open Meeting
Department of Health Professions, 6606 West Broad Street,
5th Floor, Conference Room 4, Richmond, Virginia ☎

Informal hearings will be heard to discuss disciplinary matters. Public comment will not be received.

Contact: Cheri Emma-Leigh, Operations Manager, Board of Dentistry, 6606 W. Broad St., 4th Floor, Richmond, VA 23230, telephone (804) 662-9906, FAX (804) 662-7246, (804) 662-7197/TTY ☎, e-mail denbd@dhp.state.va.us.

† **June 13, 2002 - 9:30 a.m.** -- Open Meeting
Department of Health Professions, 6606 West Broad Street,
Richmond, Virginia ☎

A panel of the board will convene a formal hearing to inquire into allegations that a certain practitioner may have violated laws governing the practice of dentistry. The panel will meet in open and closed sessions pursuant to the Code of Virginia. Public comment will not be received.

Contact: Senita Booker/Cheri Emma-Leigh, Staff, Board of Dentistry, 6606 W. Broad St., Richmond, VA 23230, telephone (804) 662-9906, FAX (804) 662-7246, (804) 662-7197/TTY ☎, e-mail denbd@dhp.state.va.us.

DESIGN-BUILD/CONSTRUCTION MANAGEMENT REVIEW BOARD

June 20, 2002 - 11 a.m. -- Open Meeting

July 18, 2002 - 11 a.m. -- Open Meeting

† **August 15, 2002 - 11 a.m.** -- Open Meeting
Virginia War Memorial, 601 South Belvidere Street,
Auditorium, Richmond, Virginia ☎ (Interpreter for the deaf provided upon request)

A meeting to review requests submitted by localities to use design-build or construction management-type contracts. Contact the Division of Engineering and Buildings to confirm the meeting. Board rules and regulations can be obtained online at www.dgs.state.va.us under the DGS Forms, Form DGS-30-904.

Contact: Freddie M. Adcock, Administrative Assistant, Department of General Services, 805 E. Broad St., Room 101, Richmond, VA 23219, telephone (804) 786-3263, FAX (804) 371-7934, (804) 786-6152/TTY ☎, e-mail fadcock@dgs.state.va.us.


Calendar of Events

BOARD OF EDUCATION

May 23, 2002 - 9 a.m. -- Open Meeting

June 26, 2002 - 9 a.m. -- Open Meeting

July 25, 2002 - 9 a.m. -- Open Meeting


General Assembly Building, 910 Capitol Square, Senate Room B, Richmond, Virginia.  (Interpreter for the deaf provided upon request)

A regular business meeting of the board. Persons who wish to speak or who require the services of an interpreter for the deaf should contact the agency in advance. Public comment will be received.


Contact: Dr. Margaret N. Roberts, Office of Policy, Department of Education, P.O. Box 2120, James Monroe Bldg., 101 N. 14th St., 25th Floor, Richmond, VA 23219, telephone (804) 225-2540, FAX (804) 225-2524, e-mail mroberts@mail.vak12ed.edu.

DEPARTMENT OF ENVIRONMENTAL QUALITY


May 21, 2002 - 9 a.m. -- Open Meeting

Department of Environmental Quality, 629 East Main Street, 1st Floor Conference Room, Richmond, Virginia. 

A regular meeting of the Virginia Ground Water Protection Steering Committee. Anyone interested in ground water protection issues is welcome to attend. Meeting minutes and agenda are available from the contact person.

Contact: Mary Ann Massie, Department of Environmental Quality, P.O. Box 10009, Richmond, VA 23240, telephone (804) 698-4042, (804) 698-4021/TTY , e-mail mamassie@deq.state.va.us.


May 22, 2002 - 10 a.m. -- Open Meeting

Virginia Historical Society, 428 North Boulevard, Richmond, Virginia. 

A meeting of the Virginia Pollution Prevention Advisory Committee.

Contact: Sharon Baxter, Department of Environmental Quality, P.O. Box 10009, Richmond, VA 23240, telephone (804) 698-4344, e-mail skbaxter@deq.state.va.us.

† June 19, 2002 - 10 a.m. -- Open Meeting


Department of Environmental Quality, Northern Regional Office, 13901 Crown Court, Woodbridge, Virginia. 

A regular meeting of the Small Business Environmental Compliance Advisory Board.

Contact: Richard G. Rasmussen, Department of Environmental Quality, P.O. Box 10009, Richmond, VA 23240, telephone (804) 698-4394, e-mail rgrasmusse@deq.state.va.us.

VIRGINIA FIRE SERVICES BOARD

† June 7, 2002 - 9 a.m. -- Open Meeting

Comfort Suites - Southpark, 931 South Avenue, Colonial Heights, Virginia.  (Interpreter for the deaf provided upon request)

Meetings of the following committees:

Fire Education and Training - 9 a.m.


Administration and Policy - 10 minutes after Fire Education and Training Committee

Fire Prevention and Control - 10 minutes after Administration and Policy Committee

Finance - 10 minutes after Fire Prevention and Control Committee

Contact: Christy L. King, Clerk to the VFSB, Virginia Fire Services Board, 101 N. 14th St., 18th Floor, Richmond, VA 23219, telephone (804) 371-0220, FAX (804) 371-0219, e-mail cking@vdfp.state.va.us.

† June 8, 2002 - 9 a.m. -- Open Meeting

Comfort Suites - Southpark, 931 South Avenue, Colonial Heights, Virginia.  (Interpreter for the deaf provided upon request)

The annual board; elections will be held. The Virginia Fallen Firefighter Memorial Service will be held at 1 p.m. on Saturday, June 8, 2002 at the Virginia State Capitol.


Contact: Christy L. King, Clerk to the VFSB, Virginia Fire Services Board, 101 North 14th Street, 18th Floor, Richmond, VA 23219, telephone (804) 371-0220, FAX (804) 371-0219, e-mail cking@vdfp.state.va.us.

BOARD OF FORESTRY

† June 5, 2002 - 8:45 a.m. -- Open Meeting


James Edmunds Tract, Off Rt. 792, Halifax County, Virginia. (Interpreter for the deaf provided upon request)

A general business meeting. A map showing location is available upon request.


Contact: Donna S. Hoy, Administrative Staff Specialist, Board of Forestry, 900 Natural Resources Dr., Suite 800, Charlottesville, VA 22903, telephone (434) 977-6555, FAX (434) 977-7749, (434) 977-6555/TTY , e-mail hoyd@dof.state.va.us.

BOARD OF FUNERAL DIRECTORS AND EMBALMERS

† May 29, 2002 - 9 a.m. -- Open Meeting

Department of Health Professions, 6606 West Broad, 5th Floor, Board Room 1, Richmond, Virginia. 

The Special Conference Committee will convene to hear possible violations of the laws and regulations governing the practice of funeral directors and embalmers.

Contact: Elizabeth Young, Executive Director, Board of Funeral Directors and Embalmers, 6606 W. Broad St., Richmond, VA 23230, telephone (804) 662-9907, FAX (804) 662-9523, (804) 662-7197/TTY 

BOARD OF GAME AND INLAND FISHERIES

June 7, 2002 - 9 a.m. -- Open Meeting

Department of Game and Inland Fisheries, 4000 West Broad Street, Richmond, Virginia. (Interpreter for the deaf provided upon request)

A meeting to address the Department of Game and Inland Fisheries' Fiscal Year 2002-2003 operating and capital budgets, and possible regulation amendments to 4 VAC 15-380, Watercraft: Motorboat Numbering, for the purpose of establishing increased fees for certificates of motorboat registration and duplicate registrations, as provided for in the 2992 Appropriation Act, Item 392. The board may address the authorized motorboat registration fees increase first through possible adoption of an emergency regulation, as authorized in the Governor's amendment to the 2002 Appropriations Act, Items 392; and second through initiation of the process to promulgate permanent regulation amendments. The board may also discuss general and administrative issues. The board may elect to hold a dinner Thursday evening, June 6, at a location and time to be determined, and it may hold a closed session at some time during the June 7 meeting.

Contact: Phil Smith, Policy Analyst, Department of Game and Inland Fisheries, 4010 W. Broad St., Richmond, VA 23230, telephone (804) 367-1000, FAX (804) 367-0488, e-mail DGIFRegs@dgif.state.va.us.

STATE BOARD OF HEALTH

May 30, 2002 - 2 p.m. -- Public Hearing

Department of Health, Main Street Station Train Shed, 1500 East Main Street, 1st Floor, EPI Conference Room, Richmond, Virginia.

July 8, 2002 - Public comments may be submitted until this date.

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the State Board of Health intends to amend regulations entitled: **12 VAC 5-90. Regulations for Disease Reporting and Control.** The purpose of the proposed action is to adopt a provision required by law regarding notification of patients reported to the state cancer registry.

Statutory Authority: §§ 32.1-12 and 32.1-70.2 of the Code of Virginia.

Contact: Diane Wollard, Ph.D., Director, Division of Surveillance and Investigation, Office of Epidemiology, Department of Health, 1500 E. Main St., Suite 123, Richmond, VA 23219, telephone (804) 786-6261, FAX (804) 786-1076, e-mail dwoollard@vdh.state.va.us.

June 21, 2002 - Public comments may be submitted until this date.

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the State Board of Health intends to repeal regulations entitled: **12 VAC 5-30. Rules and**

Regulations Governing Emergency Medical Services and adopt regulations entitled: **12 VAC 5-31. Virginia Emergency Medical Services Regulations.** The purpose of the proposed action is to consolidate diverse provisions and place them in a logical order, remove outdated provision, and reflect current technological standards.

Statutory Authority: §§ 32.1-12 and 32.1-111.4 of the Code of Virginia.

Contact: Dave Cullen, Compliance Manager, Office of EMS, Department of Health, 1538 E. Parham Rd., Richmond, VA, telephone (804) 371-3500, FAX (804) 371-3543, toll-free 1-800-523-6019, or e-mail dcullen@vdh.state.va.us.

July 22, 2002 - Public comments may be submitted until this date.

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the State Board of Health intends to amend regulations entitled: **12 VAC 5-220. Virginia Medical Care Facilities Certificate of Public Need Rules and Regulations.**

12 VAC 5-230. State Medical Facilities Plan.

12 VAC 5-240. General Acute Care Services.

12 VAC 5-250. Perinatal Services.

12 VAC 5-260. Cardiac Services.

12 VAC 5-270. General Surgical Services.

12 VAC 5-280. Organ Transplantation Services.

12 VAC 5-290. Psychiatric and Substance Abuse Treatment Services.

12 VAC 5-300. Mental Retardation Services.

12 VAC 5-310. Medical Rehabilitation Services.

12 VAC 5-320. Diagnostic Imaging Services.

12 VAC 5-340. Radiation Therapy Services.

12 VAC 5-360. Nursing Home Services.

The purpose of the proposed action is to respond to legislative changes in the law as a result of the 1999 and 2000 sessions of the General Assembly. The overall impact of the changes is a reduction in the scope of the Certificate of Public Need program. In addition, a provision of the State Medical Facilities Plan regarding liver transplantation services was found to be outdated, inadequate and otherwise inapplicable and in need of revision. The current volume standard (12) for liver transplantation procedures to ensure a successful liver transplantation program is far below the nationally recommended number of procedures (20).

Statutory Authority: §§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Contact: Carrie Eddy, Policy Analyst, Department of Health, 3600 W. Broad St., Richmond, VA 23230, telephone (804)

Calendar of Events

367-2157, FAX (804) 368-2149 or e-mail
ceddy@vdh.state.va.us.

DEPARTMENT OF HEALTH

June 7, 2002 - 10 a.m. -- Open Meeting

Fontaine Research Park, Natural Resources Building, 900 Natural Resources Drive, Charlottesville, Virginia.

A meeting of the Biosolids Use Regulations Advisory Committee to discuss issues involving the land application and agricultural uses of biosolids as governed by the Biosolids Use Regulations and proposed revisions to those regulations.

Contact: Cal Sawyer, Director of Wastewater Engineering, Department of Health, Main Street Station, 1500 E. Main St., Room 109, Richmond, Virginia 23219, telephone (804) 786-1755, e-mail csawyer@vdh.state.va.us.

June 7, 2002 - 1 p.m. -- Open Meeting

Fontaine Research Park, Natural Resources Building, 900 Natural Resources Drive, Charlottesville, Virginia.

A meeting of the Biosolids Use Information Committee to discuss issues involving land application and agricultural uses of biosolids as governed by the Biosolids Use Regulations.

Contact: Cal Sawyer, Director of Wastewater Engineering, Department of Health, Main Street Station, 1500 E. Main St., Room 109, Richmond, Virginia 23219, telephone (804) 786-1755, e-mail csawyer@vdh.state.va.us.

STATE COUNCIL OF HIGHER EDUCATION FOR VIRGINIA

† May 22, 2002 - 11:45 a.m. -- Open Meeting

Hampden-Sydney College, Settle Hall, Board Room, Hampden-Sydney, Virginia.


Agenda materials will be available on the website approximately one week prior to the meeting at www.schev.edu. Public comment will be received. Those interested in making public comment should contact the person listed below no later than 5 p.m. three business days prior to the meeting date. At the time of the request, the speaker's name, address and topic must be provided. Each speaker will be given up to three minutes to address SCHEV. Speakers are asked to submit a written copy of their remarks at the time of comment.

Contact: Lee Ann Rung, State Council of Higher Education for Virginia, 101 N. 14th St., Richmond, VA, telephone (804) 225-2602, FAX (804) 371-7911, e-mail lrung@schev.edu.


DEPARTMENT OF HISTORIC RESOURCES

State Review Board and Historic Resources Board

June 12, 2002 - 10 a.m. -- Open Meeting


Virginia Historical Society Auditorium, 428 North Boulevard, Richmond, Virginia. 

A meeting to place nominations on the National Register of Historic Places and Virginia Landmarks Register, and to approve highway markers and easements.

Contact: Marc Wagner, Register Manager, Department of Historic Resources, 2801 Kensington Ave., Richmond, VA 23221, telephone (804) 367-2323, FAX (804) 367-2391, (804) 367-2386/TTY , e-mail mwagner@dhr.state.va.us.

HOPEWELL INDUSTRIAL SAFETY COUNCIL

June 4, 2002 - 9 a.m. -- Open Meeting


Hopewell Community Center, 100 West City Point Road, Hopewell, Virginia.  (Interpreter for the deaf provided upon request)

The Local Emergency Preparedness Committee will meet as required by SARA Title III.

Contact: Robert Brown, Emergency Services Coordinator, Hopewell Industrial Safety Council, 300 N. Main St., Hopewell, VA 23860, telephone (804) 541-2298.

BOARD OF HOUSING AND COMMUNITY DEVELOPMENT

† June 17, 2002 - 10 a.m. -- Open Meeting


Department of Housing and Community Development, 501 North Second St., Richmond, Virginia. 

A regular business meeting.

Contact: Steve Calhoun, Department of Housing and Community Development, 501 N. 2nd St., Richmond, VA 23219, telephone (804) 371-7015.

State Building Code Technical Review Board

† June 21, 2002 - 10 a.m. -- Open Meeting

The Jackson Center, 501 North 2nd Street, Richmond, Virginia.  (Interpreter for the deaf provided upon request)

The Review Board hears administrative appeals concerning building and fire codes and other regulations of the department. The board also issues interpretations and formalizes recommendations to the Board of Housing and Community Development concerning future changes to the regulations.

Contact: Vernon W. Hodge, Department of Housing and Community Development, 501 N. 2nd St., Richmond, VA, telephone (804) 371-7150.

VIRGINIA HOUSING DEVELOPMENT AUTHORITY

May 21, 2002 - 9 a.m. -- Open Meeting

Virginia Housing Development Authority, 601 South Belvidere Street, Richmond, Virginia. 

A regular meeting of the Board of Commissioners to review and, if appropriate, approve the minutes from the prior monthly meeting; consider for approval and ratification mortgage loan commitments under its various programs; review the authority's operations for the prior month; and

consider such other matters and take such other actions as it may deem appropriate. Various committees of the Board of Commissioners, including the Programs Committee, the Operations Committee, the Policy Committee, and the Committee of the Whole, may also meet during the day preceding the regular meeting and before and after the regular meeting and may consider matters within their purview. The planned agenda of the meeting will be available at the offices of the authority one week prior to the date of the meeting.

Contact: J. Judson McKellar, Jr., General Counsel, Virginia Housing Development Authority, 601 S. Belvidere St., Richmond, VA 23220, telephone (804) 343-5540, FAX (804) 783-6701, toll-free (800) 968-7837, (804) 783-6705/TTY ☎

VIRGINIA INTERAGENCY COORDINATING COUNCIL

June 12, 2002 - 9:30 a.m. -- Open Meeting
Children's Hospital, 2924 Brook Road, Richmond, Virginia. ♿
(Interpreter for the deaf provided upon request)

A quarterly meeting to advise and assist the Department of Mental Health, Mental Retardation and Substance Abuse Services as lead agency for Part C (of IDEA), early intervention for infants and toddlers with disabilities and their families. Discussion will focus on issues related to Virginia's implementation of the Part C program.

Contact: LaKeishia L. White, Office Services Specialist, Department of Mental Health, Mental Retardation and Substance Abuse Services, P.O. Box 1797, Richmond, VA 23218-1797, telephone (804) 786-3710 or FAX (804) 371-7959.

DEPARTMENT OF LABOR AND INDUSTRY

NOTE: CHANGE IN MEETING DATE

† **June 13, 2002 - 10 a.m.** -- Open Meeting
J. Sargeant Reynolds Community College, North Run Business Park, 1630 E. Parham Road, Richmond, Virginia. ♿
(Interpreter for the deaf provided upon request)

A quarterly meeting of the Virginia Apprenticeship Council.

Contact: Beverley Donati, Assistant Program Manager, Department of Labor and Industry, Powers-Taylor Bldg., 13 S. 13th St., Richmond, VA 23219, telephone (804) 786-2382, FAX (804) 786-8418, (804) 786-2376/TTY ☎, e-mail bgd@doli.state.va.us.

LIBRARY OF VIRGINIA BOARD

June 10, 2002 - 7:30 a.m. -- Open Meeting
The Library of Virginia, 800 East Broad Street, Richmond, Virginia. ♿

Meetings of the board to discuss matters pertaining to The Library of Virginia and the board. Committees of the board will meet as follows:

7:30 a.m. - Executive Committee, Conference Room B.

8:15 a.m. - Public Library Development Committee, Orientation Room;
Publications and Educational Services Committee, Conference Room B;
Records Management Committee, Conference Room C.

9:30 a.m. - Archival and Information Services Committee, Orientation Room;
Collection Management Services Committee, Conference Room B;
Legislative and Finance Committee, Conference Room C.

10:30 a.m. - Library Board, Conference Room 2M.

Contact: Jean H. Taylor, Executive Secretary to the Librarian, The Library of Virginia, 800 E. Broad St., Richmond, VA 23219-2000, telephone (804) 692-3535, FAX (804) 692-3594, (804) 692-3976/TTY ☎, e-mail jtaylor@lva.lib.va.us.

LONGWOOD COLLEGE

May 23, 2002 - 10 a.m. -- Open Meeting
The Capital Club, James River East Room, 1051 East Cary Street, Richmond, Virginia. ♿

A meeting to conduct routine business of the Board of Visitors' Administration, Finance and Facilities Committee.

Contact: Jeanne Hayden, Office of the President, Longwood College, 201 High St., Farmville, VA 23909, telephone (804) 395-2004.

VIRGINIA MANUFACTURED HOUSING BOARD

† **June 20, 2002 - 10 a.m.** -- Open Meeting
Jackson Center, 501 North 2nd Street, 1st Floor, Board Room, Richmond, Virginia. ♿ (Interpreter for the deaf provided upon request)

A regular meeting to address claims and complaints against manufactured housing licensees and carry out other board functions and duties under the Manufactured Housing Licensing and Transaction Recovery Fund Regulations.

Contact: Curtis L. McIver, State Building Code Administrator, Virginia Manufactured Housing Board, State Building Code Administrative Office, 501 N. 2nd St., Richmond, VA 23219, telephone (804) 371-7160, FAX (804) 371-7092, (804) 371-7089/TTY ☎, e-mail cmciver@dhcd.state.va.us.

MARINE RESOURCES COMMISSION

May 28, 2002 - 9:30 a.m. -- Open Meeting
June 25, 2002 - 9:30 a.m. -- Open Meeting
Marine Resources Commission, 2600 Washington Avenue, 4th Floor, Newport News, Virginia. ♿

A monthly meeting.

Contact: Stephanie Montgomery, Commission Secretary, Marine Resources Commission, 2600 Washington Ave., Newport News, VA 23607, telephone (757) 247-8088, FAX

Calendar of Events

(757) 247-2020, toll-free (800) 541-4646, (757) 247-2292/TTY ☎, e-mail smont@mrc.state.va.us.

BOARD OF MEDICAL ASSISTANCE SERVICES

June 11, 2002 - 10 a.m. -- Open Meeting

Department of Medical Assistance Services, 600 East Broad Street, Board Room, Suite 1300, Richmond, Virginia. 📍

A general meeting. An agenda will be posted prior to the meeting date.

Contact: Nancy Malczewski, Communications Office, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219, telephone (804) 786-4626, FAX (804) 371-4981, (800) 343-0634/TTY ☎, e-mail nmalczewskir@dmas.state.va.us.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

May 23, 2002 - 10:30 a.m. -- Open Meeting

Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Boardroom, Richmond, Virginia. 📍

A meeting of the Medicaid Pharmacy Liaison Committee.

Contact: Marianne Rollings, Pharmacist, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219, telephone (804) 225-4268, FAX (804) 225-4393, (800) 343-0634/TTY ☎, e-mail mrollings@dmas.state.va.us.

July 5, 2002 - Public comments may be submitted until this date.

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Department of Medical Assistance Services intends to amend regulations entitled: **12 VAC 30-120. Waivered Services (Mental Retardation)**. The purpose of the proposed action is to significantly amend the mental retardation waiver program in response to issues raised by the Health Care Financing Administration and affected constituent groups.

Statutory Authority: § 32.1-325 of the Code of Virginia.

Public comments may be submitted until July 5, 2002, to Sherry Confer, Analyst, LTC Division, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219.

Contact: Victoria Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219, telephone (804) 786-7959 or FAX (804) 786-1680.

BOARD OF MEDICINE

June 21, 2002 - Public comments may be submitted until this date.

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Board of Medicine intends to amend regulations entitled: **18 VAC 85-80. Regulations Governing the Practice of Occupational Therapy**. The purpose of the proposed action is to address concerns about the adequacy of supervision for unlicensed assistants and to provide greater clarity about practice by graduates waiting for examination results. Minor changes are proposed for greater accuracy and consistency.

Statutory Authority: §§ 54.1-2400, 54.1-2956.1, and 54.1-2956.2 of the Code of Virginia.

Public comments may be submitted until June 21, 2002, to William L. Harp, M.D., Executive Director, Board of Medicine, 6606 W. Broad St. Richmond, VA 23230.

Contact: Elaine J. Yeatts, Agency Regulatory Coordinator, Department of Health Professions, 6606 W. Broad St., 4th Floor, Richmond, VA 23230, telephone (804) 662-9918, FAX (804) 662-9114 or e-mail elaine.yeatts@dhp.state.va.us.

June 21, 2002 - Public comments may be submitted until this date.

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Board of Medicine intends to amend regulations entitled: **18 VAC 85-101. Regulations Governing the Licensure of Radiologic Technologists and Radiologic Technologists-Limited**. The purpose of the proposed action is to provide an additional credential qualifying an applicant to be licensed as a radiologic technologist-limited in bone densitometry and to recognize the training course, examination and certification by the International Society for Clinical Densitometry for a limited license in that anatomical area. The proposed regulations would also clarify that a licensee who performs bone densitometry would have to get additional training and pass ARRT examinations in order to add other anatomical areas. Finally, an amendment would allow the board to accept other approved entities offering continuing education courses for bone densitometry.

Statutory Authority: §§ 54.1-2400 and 54.1-2956.8:1 of the Code of Virginia.

Public comments may be submitted until June 21, 2002, to William L. Harp, M.D., Executive Director, Board of Medicine, 6606 W. Broad St., Richmond, VA 23230.

Contact: Elaine J. Yeatts, Agency Regulatory Coordinator, Department of Health Professions, 6606 W. Broad St., 4th Floor, Richmond, VA 23230, telephone (804) 662-9918, FAX (804) 662-9114 or e-mail elaine.yeatts@dhp.state.va.us.

June 6, 2002 - 8 a.m. -- Open Meeting

Department of Health Professions, 6606 West Broad Street, 5th Floor, Conference Room 2, Richmond, Virginia. 📍 (Interpreter for the deaf provided upon request)

The board will conduct general board business, receive committee and board reports, and discuss any other items that may come before the board. The board will also meet on Friday and Saturday, June 7 and 8, to review reports,

interview licensees/applicants, conduct administrative proceedings, and make decisions on disciplinary matters. The board will also review any regulations that may come before it. The board will entertain public comments during the first 15 minutes on agenda items.

Contact: William L. Harp, M.D., Executive Director, Board of Medicine, Southern States Bldg., 6606 W. Broad St., 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9908, FAX (804) 662-9943, (804) 662-7197/TTY ☎, e-mail wharp@dhp.state.va.us.

June 7, 2002 - 1 p.m. -- Open Meeting

Department of Health Professions, 6606 West Broad Street, 5th Floor, Richmond, Virginia. ♿ (Interpreter for the deaf provided upon request)

A meeting of the Credentials Committee will be held in open and closed session to conduct general business, interview and review medical credentials of applicants applying for licensure in Virginia, and discuss any other items which may come before the committee.

Contact: William L. Harp, MD, Executive Director, Board of Medicine, 6606 W. Broad St., 4th Floor, Richmond, VA 23230, telephone (804) 662-7005, FAX (804) 662-9517, (804) 662-7197/TTY ☎

Informal Conference Committee

May 22, 2002 - 9 a.m. -- Open Meeting

June 19, 2002 - 8:45 a.m. -- Open Meeting

† July 24, 2002 - 9:15 a.m.

Williamsburg Marriott Hotel, 50 Kingsmill Road, Williamsburg, Virginia.

June 13, 2002 - 9:30 a.m. -- Open Meeting

Holiday Inn Select, 2801 Plank Road, Fredericksburg, Virginia. ♿

† July 10, 2002 - 8:45 a.m. -- Open Meeting

Department of Health Professions, 6606 West Broad Street, Richmond, Virginia.

A meeting to inquire into allegations that certain practitioners may have violated laws and regulations governing the practice of medicine and other healing arts in Virginia. The committee will meet in open and closed sessions pursuant to the Code of Virginia. Public comment will not be received.

Contact: Peggy Sadler or Renee Dixon, Staff, Board of Medicine, 6606 W. Broad St., Richmond, VA 23230, telephone (804) 662-7332, FAX (804) 662-9517, (804) 662-7197/TTY ☎, e-mail Peggy.Sadler@dhp.state.va.us.

STATE MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES BOARD

June 5, 2002 - 6:30 p.m. -- Public Hearing

Dumbarton Area Library, 6800 Staples Mill Road, Richmond, Virginia.

June 21, 2002 - Public comments may be submitted until this date.

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the State Mental Health, Mental Retardation and Substance Abuse Services Board intends to amend regulations entitled: **12 VAC 35-190. Regulations Establishing Procedures for Voluntarily Admitting Persons who are Mentally Retarded to State Mental Retardation Facilities.** The purpose of the proposed action is to amend the regulations to update current provisions in order to reflect current practice and promote appropriate admissions to state training centers.

Statutory Authority: §§ 37.1-10 and 37.1-65.1 of the Code of Virginia.

Contact: Wendy V. Brown, Policy Analyst, Department of Mental Health, Mental Retardation and Substance Abuse Services, P.O. Box 1797, Richmond, VA 23218-1797, telephone (804) 225-2252, FAX (804) 371-0092 or e-mail wbrown@dmhmrsas.state.va.us.

STATE MILK COMMISSION

May 22, 2002 - 11 a.m. -- Open Meeting

102 East Buck Avenue, Rural Retreat, Virginia.

A regular meeting to consider industry issues, distributor licensing, base transfers, and reports from staff. The commission offers anyone in attendance an opportunity to speak at the conclusion of the agenda. Those persons requiring special accommodations should notify the agency meeting contact at least five working days prior to the meeting date so that suitable arrangements can be made.

Contact: Edward C. Wilson, Jr., Deputy Administrator, State Milk Commission, Ninth St. Office Bldg., 202 N. Ninth St., Room 915, Richmond, VA 23219, telephone (804) 786-2013, FAX (804) 786-3779, e-mail ewilson@smc.state.va.us.

DEPARTMENT OF MINES, MINERALS AND ENERGY

† May 21, 2002 - 9 a.m. -- Open Meeting

Southwest Virginia Higher Education Center, Campus of Virginia Highlands Community College, Abingdon, Virginia ♿ (Interpreter for the deaf provided upon request)

The Virginia Gas and Oil Board will conduct its regularly scheduled meeting to consider petitions filed by applicants for pooling applications and disbursement of funds from the board's escrow account. The public may address the board on individual items as they are called for hearing by the board. Special accommodations for the disabled will be made available at the public meeting on request. Anyone needing special accommodations should contact the Department of Mines, Minerals and Energy, Division of Gas and Oil at the numbers listed below.

Contact: Bob Wilson, Director, Division of Gas and Oil, Department of Mines, Minerals and Energy, P.O. Box 1416, Abingdon, VA 24212, telephone (276) 676-5423, FAX (276) 676-5459, (800) 828-1120/TTY ☎, e-mail bwx@mme.state.va.us.

Calendar of Events

DEPARTMENT OF MOTOR VEHICLES

June 12, 2002 - 8 a.m. -- Open Meeting
Department of Motor Vehicles, 2300 West Broad Street, Richmond Virginia. (Interpreter for the deaf provided upon request)

A regular business meeting of the Medical Advisory Board.

Contact: Jacquelin Branche, Assistant Division Manager, Department of Motor Vehicles, 2300 W. Broad St., Richmond VA 23220, telephone (804) 367-0531, FAX (804) 367-1604, e-mail dmvj3b@dmv.state.va.us.

June 13, 2002 - 9 a.m. -- Open Meeting
† **August 8, 2002 - 9 a.m.** -- Open Meeting
Department of Motor Vehicles, 2300 West Broad Street, Room 702, Richmond, Virginia.

A meeting of the Digital Signature Implementation Workgroup. Meetings will be held on the second Thursday of every other month from 9 a.m. until noon at the location noted above unless otherwise noted. The room will be open for coffee and pre-session business at 8:30 a.m.; the business session will begin at 9.

Contact: Vivian Cheatham, Executive Staff Assistant, Department of Motor Vehicles, 2300 W. Broad St., Richmond, VA 23220, telephone (804) 367-6870, FAX (804) 367-6631, toll-free (866) 68-5463, e-mail dmvvrc@dmv.state.va.us.

VIRGINIA MUSEUM OF FINE ARTS

June 20, 2002 - Noon -- Open Meeting
Virginia Museum of Fine Arts, CEO 2nd Floor Meeting Room, 2800 Grove Avenue, Richmond, Virginia

A meeting of the Executive/Finance Committee to approve the annual budget. Public comment will not be received.

Contact: Suzanne Broyles, Secretary of the Museum, Virginia Museum of Fine Arts, 2800 Grove Avenue, Richmond, VA 23221, telephone (804) 340-1503, FAX (804) 340-1502, (804) 340-1401/TTY, e-mail sbroyles@vmfa.state.va.us

BOARD OF NURSING

May 20, 2002 - 9 a.m. -- Open Meeting
May 22, 2002 - 9 a.m. -- Open Meeting
May 23, 2002 - 8:30 a.m. -- Open Meeting
July 15, 2002 - 9 a.m. -- Open Meeting
July 17, 2002 - 9 a.m. -- Open Meeting
July 18, 2002 - 9 a.m. -- Open Meeting
Department of Health Professions, 6606 West Broad Street, 5th Floor, Conference Room 2, Richmond, Virginia.

A panel of the board will conduct formal hearings with licensees or certificate holders. Public comment will not be received.

Contact: Nancy K. Durrett, R.N., Executive Director, Board of Nursing, 6606 W. Broad St., 4th Floor, Richmond, VA 23230, telephone (804) 662-9909, FAX (804) 662-9512, (804) 662-7197/TTY, e-mail nursebd@dhp.state.va.us.

May 21, 2002 - 9 a.m. -- Open Meeting
Department of Health Professions, 6606 West Broad Street, 5th Floor, Conference Room 2, Richmond, Virginia.

A general business meeting including action on several regulatory and disciplinary matters as presented on the agenda. The board may adopt emergency regulations for volunteer practice by out-of-state nurses and may adopt proposed regulations pursuant to regulatory review recommendations. Public comment will be received at approximately 11 a.m.

Contact: Nancy K. Durrett, R.N., Executive Director, Board of Nursing, Southern States Bldg., 6606 W. Broad St., 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9909, FAX (804) 662-9512, (804) 662-7197/TTY, e-mail ndurrett@dhp.state.va.us.

Special Conference Committee

June 4, 2002 - 8:30 a.m. -- Open Meeting
June 10, 2002 - 8:30 a.m. -- Open Meeting
June 12, 2002 - 8:30 a.m. -- Open Meeting
June 18, 2002 - 8:30 a.m. -- Open Meeting
June 20, 2002 - 8:30 a.m. -- Open Meeting
June 25, 2002 - 8:30 a.m. -- Open Meeting
Department of Health Professions, 6606 West Broad Street, 5th Floor, Conference Room 3, Richmond, Virginia.

June 26, 2002 - 8:30 a.m. -- Open Meeting
† **July 30, 2002 - 9 a.m.** -- Open Meeting
† **August 1, 2002 - 9 a.m.** -- Open Meeting
† **August 5, 2002 - 9 a.m.** -- Open Meeting
† **August 6, 2002 - 9 a.m.** -- Open Meeting
† **August 12, 2002 - 9 a.m.** -- Open Meeting
† **August 13, 2002 - 9 a.m.** -- Open Meeting
Department of Health Professions, 6606 West Broad Street, 5th Floor, Conference Room 4, Richmond, Virginia.

A Special Conference Committee, comprised of two or three members of the Virginia Board of Nursing, will conduct informal conferences with licensees or certificate holders. Public comment will not be received.

Contact: Nancy K. Durrett, R.N., Executive Director, Board of Nursing, 6606 W. Broad St., 4th Floor, Richmond, VA 23230, telephone (804) 662-9909, FAX (804) 662-9512, (804) 662-7197/TTY, e-mail nursebd@dhp.state.va.us.

BOARD OF PHARMACY

† **June 4, 2002 - 9 a.m.** -- Open Meeting
Department of Health Professions, 6606 West Broad Street, 5th Floor, Conference Room 4, Richmond, Virginia.

The Special Conference Committee will discuss disciplinary matters. Public comments will not be received.

Contact: Elizabeth Scott Russell, Executive Director, Board of Pharmacy, 6606 W. Broad St., 4th Floor, Richmond, VA 23230, telephone (804) 662-9911, FAX (804) 662-9313.

BOARD OF PHYSICAL THERAPY

† **July 12, 2002 - 9 a.m.** -- Open Meeting
Department of Health Professions, 6606 West Broad Street,
5th Floor, Conference Room 3, Richmond, Virginia. ☎

July 19, 2002 - Public comments may be submitted until this date.

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Board of Physical Therapy intends to amend regulations entitled: **18 VAC 112-20. Regulations Governing the Practice of Physical.** The purpose of the proposed action is to establish requirements to ensure continuing competency in accordance with a statutory mandate. Proposed regulations will replace emergency regulations currently in effect.

Statutory Authority: §§ 54.1-2400, 54.1-3474 and 54.1-3480.1 of the Code of Virginia.

Public comments may be submitted until July 19, 2002, to Elizabeth Young, Executive Director, Board of Physical Therapy, 6606 W. Broad St., Richmond, VA 23230.

Contact: Elaine J. Yeatts, Regulatory Coordinator, 6606 W. Broad St., Richmond, VA 23230, telephone (804) 662-9918, FAX (804) 662-9114 or e-mail elaine.yeatts@dhp.state.va.us.

POLYGRAPH EXAMINERS ADVISORY BOARD

June 19, 2002 - 10 a.m. -- Open Meeting
Department of Professional and Occupational Regulation,
3600 West Broad Street, Richmond, Virginia. ☎ (Interpreter for the deaf provided upon request)

A meeting to conduct board business. Persons desiring to participate in the meeting and requiring special accommodations or interpreter services should contact the department at least 10 days prior to the meeting so that suitable arrangements can be made. The department fully complies with the Americans with Disabilities Act.

Contact: Mark N. Courtney, Assistant Director, Department of Professional and Occupational Regulation, 3600 W. Broad St., Richmond, VA 23230-4917, telephone (804) 367-8514, FAX (804) 367-2475, (804) 367-9753/TTY ☎, e-mail polygraph@dpor.state.va.us.

DEPARTMENT OF REHABILITATIVE SERVICES

† **June 5, 2002 - 9:30 a.m.** -- Open Meeting
Department of Rehabilitative Services, 8004 Franklin Farms Drive, Richmond, Virginia. ☎ (Interpreter for the deaf provided upon request)

A regular business meeting of the Commonwealth Neurotrauma Initiative Advisory Board with presentations by two grant recipients.

Contact: Sandra Prince, Program Specialist, Brain Injury/Spinal Cord Injury Services, Department of Rehabilitative Services, 8004 Franklin Farms Drive, Richmond, VA 23229, telephone (804) 662-7021, FAX (804)

662-7122, toll-free (800) 552-5019, (804) 662-9040/TTY ☎, e-mail princesw@drs.state.va.us.

VIRGINIA RESOURCES AUTHORITY

June 11, 2002 - 9 a.m. -- Open Meeting
NOTE: CHANGE IN MEETING LOCATION
McGuire Woods, L.L.P., World Trade Center, Norfolk, Virginia.

† **July 9, 2002 - 9 a.m.** -- Open Meeting
† **August 13, 2002 - 9 a.m.** -- Open Meeting
Virginia Resources Authority, 707 East Main Street, 2nd Floor Conference Room, Richmond, Virginia. ☎

A regular meeting of the Board of Directors to (i) review and, if appropriate, approve the minutes from the most recent monthly meeting; (ii) review the authority's operations for the prior month; (iii) review applications for loans submitted to the authority for approval; (iv) consider loan commitments for approval and ratification under its various programs; (v) approve the issuance of any bonds; (vi) review the results of any bond sales; and (vii) consider such other matters and take such other actions as it may deem appropriate. Various committees of the Board of Directors may also meet immediately before or after the regular meeting and consider matters within their purview. The planned agenda of the meeting and any committee meetings will be available at the offices of the authority one week prior to the date of the meeting. Any person who needs any accommodation in order to participate in the meeting should contact the authority at least 10 days before the meeting so that suitable arrangements can be made.

Contact: Bonnie R.C. McRae, Executive Assistant, Virginia Resources Authority, 707 E. Main St., Suite 1350, Richmond, VA 23219, telephone (804) 644-3100, FAX (804) 644-3109, e-mail bmcrae@vra.state.va.us.

DEPARTMENT FOR RIGHTS OF VIRGINIANS WITH DISABILITIES


† **June 18, 2002 - 4 p.m.** -- Public Hearing
General Assembly Building, 9th and Broad Streets, House Room D, Richmond, Virginia. ☎ (Interpreter for the deaf provided upon request)

This public hearing relates to the Governor's intent to redesignate Virginia's Protection and Advocacy System. Individuals wishing to make public comment on the redesignation can do so at the public hearing between 4 p.m. and 6 p.m. Individuals requiring special accommodations or assistance should contact DRVD at least five business days prior to the hearing date. For more information on the intent to redesignate contact DRVD at 1-800-552-3962 or 804-225-2061, or e-mail wareka@drvd.state.va.us.

Contact: Kimberly Ware, Program Operations Coordinator, Department for Rights of Virginians with Disabilities, 202 N. 9th St., 9th Floor, Richmond, VA 23219, telephone (804) 225-2061, FAX (804) 225-3221, toll-free (800) 552-3962, (804) 225-2042/TTY ☎, e-mail wareka@drvd.state.va.us.

Calendar of Events

SEWAGE HANDLING AND DISPOSAL APPEAL REVIEW BOARD

May 22, 2002 - 10 a.m. -- Open Meeting
General Assembly Building, 910 Capitol Street, Senate Room
B, Richmond, Virginia. 

A meeting to hear appeals of health department denials of
septic tank permits.

Contact: Susan C. Sherertz, Business Manager, Department
of Health, 1500 E. Main St., Room 115, Richmond, VA,
telephone (804) 371-4236, FAX (804) 225-4003, e-mail
ssherertz@vdh.state.va.us.


VIRGINIA SMALL BUSINESS FINANCING AUTHORITY

May 28, 2002 - 10 a.m. -- Open Meeting
Department of Business Assistance, 707 East Main Street,
3rd Floor, Richmond, Virginia. 

A meeting to review applications for loans submitted to the
authority for approval and to conduct general business of
the board. Meeting time is subject to change depending
upon the agenda of the board.

Contact: Scott E. Parsons, Executive Director, Department of
Business Assistance, P.O. Box 446, Richmond, VA 23218-
0446, telephone (804) 371-8254, FAX (804) 225-3384, e-mail
sparsons@dba.state.va.us.

STATE BOARD OF SOCIAL SERVICES

May 23, 2002 - 9 a.m. -- Open Meeting
General Assembly Building, 9th and Broad Streets, House
Room C, Richmond, Virginia. 

A meeting of the Secretary's Child Support Guideline
Review Panel. All states are required to establish guidelines
for determining the amount of financial and medical child
support owed by both parents. Virginia's guideline is
contained in §§ 20-108.1 and 20-108.2 of the Code of
Virginia. Virginia law requires a panel review of the
guideline every three years. The panel consists of
noncustodial parents, custodial parents, child advocates,
attorneys, judges, the Executive Branch and members of
the Virginia Senate and House of Delegates.

Contact: Bill Brownfield, Staff Director, State Board of Social
Services, 730 E. Broad St., 4th Floor, Richmond, VA 23219-
1849, telephone (804) 692-2401, FAX (804) 692-2410.

June 7, 2002 - Public comments may be submitted until this
date.

Notice is hereby given in accordance with § 2.2-4007 that
the State Board of Social Services intends to adopt
regulations entitled: **22 VAC 40-730. Investigation of
Child Abuse and Neglect in Out of Family Complaints.**
The purpose of the proposed action is to emphasize that
child protective services out of family investigations are to
be conducted as joint investigations in cases involving an

employee at a state licensed facility for children, or an
employee of a public or private school.

Statutory Authority: §§ 63.1-25, 63.1-248.6 and 63.1-248.7:1
of the Code of Virginia.

Contact: Jesslyn Cobb, CPS Program Consultant, State
Board of Social Services, 730 E. Broad St., 2nd Floor,
Richmond, VA 23219, telephone (804) 692-1255 or FAX (804)
692-2215.

June 7, 2002 - Public comments may be submitted until this
date.

Notice is hereby given in accordance with § 2.2-4007 of the
Code of Virginia that the State Board of Social Services
intends to amend regulations entitled: **22 VAC 40-720.
Child Protective Services Release of Information to
Family Advocacy Representatives of the United States
Armed Forces.** The regulation mandates sharing of
information in founded cases of child abuse between social
services and the Family Advocacy Program; the definition of
"founded" is being amended to conform with the definition of
"founded" in the Child Protective Services regulation (22
VAC 40-705).

Statutory Authority: §§ 63.1-25 and 63.248.6 of the Code of
Virginia.

Contact: Jesslyn Cobb, CPS Program Consultant, State
Board of Social Services, 730 E. Broad St., 2nd Floor,
Richmond, VA 23219, telephone (804) 692-1255 or FAX (804)
692-2215.

† June 12, 2002 - 1 p.m. -- Public Hearing
Department of Social Services, 730 East Broad Street, Lower
Level 1, Richmond, Virginia.

July 19, 2002 - Public comments may be submitted until this
date.

Notice is hereby given in accordance with § 2.2-4007 of the
Code of Virginia that the State Board of Social Services
intends to amend regulations entitled: **22 VAC 40-705.
Child Protective Services.** The purpose of the proposed
action is to establish in the permanent regulations the
provisions of the current emergency regulations, which
allow for statewide implementation of a CPS differential
response system. Other changes strengthen the
regulations or reflect recent legislation.

Statutory Authority: §§ 63.1-25 and 63.1-248.6 of the Code of
Virginia.

Contact: Betty Jo Zarris, CPS Policy Specialist, Department
of Social Services, 730 E. Broad St., 2nd Floor, Richmond, VA
23219, telephone (804) 692-1220, FAX (804) 692-2215 or e-
mail bjz900@dss.state.va.us.

† **June 19, 2002 - 9 a.m.** -- Open Meeting

† **June 20, 2002 - 9 a.m.** -- Open Meeting

Lamplighter Restaurant, 201 Virginia Avenue, Clarksville, Virginia.

A formal business meeting.

Contact: Pat Rengnerth, State Board Liaison, State Board of Social Services, 730 E. Broad St., Suite 812, Richmond, VA 23219-1849, telephone (804) 692-1826, FAX (804) 692-1962.

† **June 21, 2002 - 10 a.m.** -- Open Meeting

Department of Social Services, 730 East Broad Street, 8th Floor, Conference Room, Richmond, Virginia. ☎

A regular business meeting of the Board of Trustees of the Family and Children's Trust Fund.

Contact: Nan McKenney, Executive Director, State Board of Social Services, 730 E. Broad St., 8th Floor Richmond, VA 23219-1849, telephone (804) 692-1823, FAX (804) 692-1869.

COUNCIL ON TECHNOLOGY SERVICES

June 13, 2002 - 9:15 a.m. -- Open Meeting

Department of Technology Planning, 110 South 7th Street, Suite 135, Conference Room, Richmond, Virginia. ☎

A monthly meeting of the Dashboard Project Workgroup. To expedite security procedures, please contact George Williams at the Department of Technology Planning at gwilliams@ntp.state.va.us or (804) 371-2771 to include your name on the list of attendees that will be given to building security.

Contact: Chris Saneda, Chief Information Officer, Department of Alcoholic Beverage Control, 2901 Hermitage Rd., Richmond, VA 23220, telephone (804) 213-4483, FAX (804) 213-4486, e-mail chris.saneda@abc.state.va.us.

STATE WATER CONTROL BOARD

June 11, 2002 - 2 p.m. -- Public Hearing

Department of Environmental Quality, West Central Regional Office, 3019 Peters Creek Road, Roanoke, Virginia.

June 11, 2002 - 2 p.m. -- Public Hearing

Piedmont Regional Office, 4949-A Cox Road, Glen Allen, Virginia.

July 8, 2002 - Public comments will be received until this date.

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the State Water Control Board intends to amend regulations entitled: **9 VAC 25-180. Virginia Pollutant Discharge Elimination System (VPDES) General Permit Regulation for Discharges of Storm Water from Construction Activities.** The purpose of the proposed action is to amend the existing construction general permit regulation to add coverage for storm water discharges from small construction activities. A question and answer period will be held one half hour prior to the public hearing at each location.

Statutory Authority: § 62.1-44.15 of the Code of Virginia.

Contact: Burton Tuxford, Storm Water Coordinator, Department of Environmental Quality, 629 E. Main St., Richmond, VA 23219, telephone (804) 698-4086, FAX (804) 698-4032, e-mail brtuxford@deq.state.va.us.

June 11, 2002 - 2 p.m. -- Public Hearing

Department of Environmental Quality, West Central Regional Office, 3019 Peters Creek Road, Roanoke, Virginia.

June 11, 2002 - 2 p.m. -- Public Hearing

Piedmont Regional Office, 4949-A Cox Road, Glen Allen, Virginia.

July 8, 2002 - Public comments will be received until this date.

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the State Water Control Board intends to adopt regulations entitled: **9 VAC 25-750. Virginia Pollutant Discharge Elimination System (VPDES) General Permit Regulation for Discharges of Storm Water from Small Municipal Separate Storm Sewer Systems.** The purpose of the proposed action is to adopt a general permit regulation to authorize storm water discharges from small regulated municipal separate storm sewer systems. A question and answer period will be held one half hour prior to the public hearing at each location.

Statutory Authority: § 62.1-44.15 of the Code of Virginia.

Contact: Burton Tuxford, Storm Water Coordinator, Department of Environmental Quality, 629 E. Main St., Richmond, VA 23219, telephone (804) 698-4086, FAX (804) 698-4032, e-mail brtuxford@deq.state.va.us.

BOARD FOR WATERWORKS AND WASTEWATER WORKS OPERATORS

June 20, 2002 - 8:30 a.m. -- Open Meeting

Department of Professional and Occupational Regulation, 3600 West Broad Street, Conference Room 5W, Richmond, Virginia. ☎

A meeting to conduct routine business. A public comment period will be held at the beginning of the meeting.

Contact: David Dick, Assistant Director, Department of Professional and Occupational Regulation, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-2648, FAX (804) 367-6128, (804) 367-9753/TTY ☎, e-mail waterwasteoper@dpor.state.va.us.

VIRGINIA WORKFORCE COUNCIL

NOTE: CHANGE IN MEETING TIME

June 12, 2002 - 2:30 p.m. -- Open Meeting

Holiday Inn University Area and Conference Center, 1901 Emmet Street, Monroe and Madison Rooms, Charlottesville, Virginia. ☎ (Interpreter for the deaf provided upon request)

Calendar of Events

Agenda items are WIA local strategic plans, training provider waivers, council strategic plan, and local WIB report. Public comment will be received at 3:30 p.m. Five minutes per speaker and a written copy of the remarks is requested.

Contact: Gail Robinson, Liaison, Virginia Employment Commission, P.O. Box 1358, Richmond, VA 23218-1358, telephone (804) 225-3070, FAX (804) 225-2190, (800) 828-1120/TTY ☎, e-mail grobinson@vec.state.va.us.

INDEPENDENT

STATE LOTTERY BOARD

June 19, 2002 - 9:30 a.m. -- Open Meeting
Pocahontas Building, 900 East Main Street, Richmond, Virginia. ♿

A regular meeting. Public comment will be received at the beginning of the meeting.

Contact: Barbara L. Robertson, Board, Legislative and Regulatory Coordinator, State Lottery Department, 900 E. Main St., Richmond, VA 23219, telephone (804) 692-7105, FAX (804) 692-7775, e-mail brobertson@valottery.state.va.us.

VIRGINIA RETIREMENT SYSTEM

† August 13, 2002 - Noon -- Open Meeting
VRS Headquarters, 1200 East Main Street, Richmond, Virginia. ♿

A regular meeting of the Optional Retirement Plan Advisory Committee.

Contact: Darla K. Glazier, Office Manager, Virginia Retirement System, 1200 E. Main St., Richmond, VA 23219, telephone (804) 649-8059, FAX (804) 786-1541, toll-free (888) 827-3847, (804) 344-3190/TTY ☎, e-mail dglazier@vrs.state.va.us.

† August 14, 2002 - Noon -- Open Meeting
VRS Headquarters, 1200 East Main Street, Richmond, Virginia. ♿

Meetings of the following committees:

Audit and Compliance Committee - Noon
Benefits and Actuarial Committee - 1 p.m.
Administration and Personnel Committee - 2:30 p.m.
Investment Advisory Committee - 3 p.m.

Contact: Darla K. Glazier, Office Manager, Virginia Retirement System, P.O. Box 2500, Richmond, VA 23218, telephone (804) 649-8059, FAX (804) 786-1541, toll-free (888) 827-3847, (804) 344-3190/TTY ☎, e-mail dkestner@vrs.state.va.us.

† August 15, 2002 - 9 a.m. -- Open Meeting
VRS Headquarters, 1200 East Main Street, Richmond, Virginia. ♿

A regular meeting of the Board of Trustees.

Contact: Darla K. Glazier, Office Manager, Virginia Retirement System, P.O. Box 2500, Richmond, VA 23218, telephone (804) 649-8059, FAX (804) 786-1541, toll-free (888) 827-3847, (804) 344-3190/TTY ☎, e-mail dkestner@vrs.state.va.us.

LEGISLATIVE

VIRGINIA CODE COMMISSION

June 19, 2002 - 10 a.m. -- Open Meeting
General Assembly Building, 9th and Broad Streets, 6th Floor, Speaker's Conference Room, Richmond, Virginia. ♿

A regular meeting.

Contact: Jane Chaffin, Registrar of Regulations, Virginia Code Commission, General Assembly Bldg., 910 Capitol Street, Richmond, VA 23219, telephone (804) 786-3591, FAX (804) 692-0625, e-mail jchaffin@leg.state.va.us.

CONSUMER ADVISORY BOARD OF THE VIRGINIA ELECTRIC UTILITY RESTRUCTURING ACT

† June 18, 2002 - 10 a.m. -- Open Meeting
General Assembly Building, 9th and Broad Streets, Senate Room B, Richmond, Virginia. ♿

A regular meeting. Individuals requiring interpreter services or other assistance should contact Tommy Gilman.

Contact: Tommy Gilman, Senate Committee Operations, P.O. Box 396, Richmond, VA 23218, telephone (804) 698-7450 or (804) 698-7419/TDD ☎

VIRGINIA HOUSING STUDY COMMISSION

† May 23, 2002 - 1 p.m. -- Open Meeting
General Assembly Building, 9th and Broad Streets, Senate Room A, Richmond, Virginia. ♿

The 2002 organizational meeting to brief new commission members and review 2002 agenda (SJR 111), including reimbursement of certain litigation expenses relating to eminent domain, consumer protection relating to new building products, predatory mortgage lending, and fair housing enforcement.

Contact: Nancy D. Blanchard, Virginia Housing Study Commission, 601 S. Belvidere St., Richmond, VA 23220, telephone (804) 343-5565 or FAX (804) 783-6733.

CHRONOLOGICAL LIST

OPEN MEETINGS

May 20

Nursing, Board of

May 21

† Agriculture and Consumer Services, Department of
- Consumer Affairs Advisory Committee

- Farmland Preservation Task Force
- † Air Pollution Control, State
- Alzheimer's Disease and Related Disorders Commission
- † Asbestos, Lead and Home Inspectors, Virginia Board for Environmental Quality, Department of
 - Virginia Ground Water Protection Steering Committee
- Housing Development Authority, Virginia
 - Board of Commissioners
- † Mines, Minerals and Energy, Department of
 - Virginia Gas and Oil Board
- Nursing, Board of

May 22

- Charitable Gaming Commission
- Environmental Quality, Department of
 - Pollution Prevention Advisory Committee
- † Higher Education for Virginia, State Council of Medicine, Board of
 - Informal Conference Committee
- Milk Commission, State
- Nursing, Board of
- Sewage Handling and Disposal Appeal Review Board

May 23

- Conservation and Recreation, Department of
 - Mason Neck State Park Technical Advisory Committee
- Education, Board of
- † Housing Study Commission, Virginia
- Longwood College
 - Administration, Finance and Facilities Committee
- Medical Assistance Services, Department of
- Nursing, Board of
- Social Services, State Board of
 - Secretary's Child Support Guideline Review Panel

May 28

- † Air Pollution Control Board, State
- Compensation Board
- Marine Resources Commission
- Small Business Financing Authority, Virginia

May 29

- † Funeral Directors and Embalmers, Board of

May 30

- † Conservation and Recreation, Department of
- † Counseling, Board of
 - Credentials Committee

May 31

- † Counseling, Board of
 - Regulatory/Supervision/Legislative Committee
- Dentistry, Board of
 - Special Conference Committee

June 1

- † Conservation and Recreation, Department of
 - Virginia Cave Board

June 4

- Hopewell Industrial Safety Council
- Nursing, Board of
 - Special Conference Committee
- † Pharmacy, Board of
 - Special Conference Committee

June 5

- † Accountancy, Board of
 - Enforcement Committee
- † Contractors, Board for
- † Forestry, Board of

- † Rehabilitative Services, Department of
 - Commonwealth Neurotrauma Initiative Advisory Board

June 6

- Architects, Professional Engineers, Land Surveyors, Certified Interior Designers, and Landscape Architects, Board for
- Conservation and Recreation, Department of
 - Falls of the James Scenic River Advisory Board
- Medicine, Board of

June 7

- Art and Architectural Review Board
- † Fire Services Board, Virginia
 - Administration and Policy Committee
 - Finance Committee
 - Fire Education and Training Committee
 - Fire Prevention and Control Committee
- Game and Inland Fisheries, Board of
- Health, Department of
 - Biosolids Use Information Committee
 - Biosolids Use Regulations Advisory Committee
- Medicine, Board of
 - Credentials Committee

June 8

- Blind and Vision Impaired, Department for the
 - Statewide Rehabilitation Council for the Blind
- † Fire Services Board, Virginia

June 10

- Library of Virginia
 - Archival and Information Services Committee
 - Collection Management Services Committee
 - Executive Committee
 - Legislative and Finance Committee
 - Publications and Educational Services Committee
 - Public Library Development Committee
 - Records Management Committee
- Nursing, Board of
 - Special Conference Committee

June 11

- Medical Assistance Services, Board of
- Resources Authority, Virginia
 - Board of Directors

June 12

- Conservation and Recreation, Department of
 - Bear Creek Lake State Park Technical Advisory Committee
- Historic Resources, Department of
 - State Review Board and Historic Resources Board
- Interagency Coordinating Council, Virginia
- Motor Vehicles, Department of
 - Medical Advisory Board
- Nursing, Board of
 - Special Conference Committee
- Workforce Council, Virginia

June 13

- Conservation and Recreation, Department of
 - Mason Neck State Park Technical Advisory Committee
- † Dentistry, Board of
- † Labor and Industry, Department of
 - Virginia Apprenticeship Council
- Medicine, Board of
 - Informal Conference Committee
- Motor Vehicles, Department of

Calendar of Events

- Digital Signature Implementation Workgroup
- Technology Services, Council on
- Dashboard Project Workgroup
- June 17**
 - † Housing and Community Development, Board of
- June 18**
 - † Deaf and Hard-of-Hearing, Department for the
 - Virginia Relay Advisory Council
 - † Electrical Utility Restructuring Act, Consumer Advisory Board of the Virginia Nursing, Board of
 - Special Conference Committee
 - † Rights of Virginian's with Disabilities, Department for
- June 19**
 - † Agriculture and Consumer Services, Department of
 - Virginia State Apple Board
 - Code Commission, Virginia
 - † Environmental Quality, Department of
 - Small Business Environmental Compliance Advisory Board
 - Lottery Board, State
 - Medicine, Board of
 - Informal Conference Committee
 - Polygraph Examiners Advisory Board
 - † Social Services, State Board of
- June 20**
 - † Assistive Technology Loan Fund Authority
 - Design-Build/Construction Management Review Board
 - † Manufactured Housing Board, Virginia
 - Museum of Fine Arts, Virginia
 - Executive/Finance Committee
 - Nursing, Board of
 - Special Conference Committee
 - † Social Services, State Board of
 - Waterworks and Wastewater Works Operators, Virginia Board for
- June 21**
 - † Housing and Community Development, Department of
 - State Building Code Technical Review Board
 - † Social Services, State Board of
 - Family and Children's Trust Fund Board of Trustees
- June 25**
 - † Compensation Board
 - Marine Resources Committee
 - Nursing, Board of
 - Special Conference Committee
- June 26**
 - Education, Board of
 - Nursing, Board of
 - Special Conference Committee
- July 9**
 - † Resources Authority, Virginia
 - Board of Directors
- July 10**
 - † Medicine, Board of
 - Informal Conference Committee
- July 11**
 - † Conservation and Recreation, Department of
 - Falls of the James Scenic River Advisory Board
- July 12**
 - Art and Architectural Review Board
 - † Physical Therapy, Board of

- July 15**
 - Nursing, Board of
- July 16**
 - Asbestos, Lead, and Home Inspectors, Virginia Board for
- July 17**
 - Nursing, Board of
- July 18**
 - Design-Build/Construction Management Review Board
 - Nursing, Board of
- July 24**
 - † Medicine, Board of
 - Informal Conference Committee
- July 25**
 - Education, Board of
- July 30**
 - † Nursing, Board of
 - Special Conference Committee
- August 1**
 - † Nursing, Board of
 - Special Conference Committee
- August 2**
 - Art and Architectural Review Board
 - † Nursing, Board of
 - Special Conference Committee
- August 5**
 - † Nursing, Board of
 - Special Conference Committee
- August 6**
 - † Nursing, Board of
 - Special Conference Committee
- August 8**
 - † Motor Vehicles, Department of
 - Digital Signature Implementation Workgroup
- August 12**
 - † Nursing, Board of
 - Special Conference Committee
- August 13**
 - † Nursing, Board of
 - Special Conference Committee
 - † Resources Authority, Virginia
 - Board of Directors
 - † Retirement System, Virginia
 - Optional Retirement Plan Advisory Committee
- August 14**
 - † Retirement System, Virginia
 - Administration and Personnel Committee
 - Audit and Compliance Committee
 - Benefits and Actuarial Committee
 - Investment Advisory Committee
- August 15**
 - † Design-Build/Construction Management Review Board
 - † Retirement System, Virginia

PUBLIC HEARINGS

- May 30**
 - Health, State Board of
- May 31**
 - † Counseling, Board of
- June 5**
 - Mental Health, Mental Retardation and Substance Abuse Services Board, State

June 11

Water Control Board, State

June 12

† Social Services, State Board of

June 27

† Air Pollution Control Board, State